CONCEPT DERMA
CLINIC

Full Name:	Date:	Date of Birth:

Permission to contact GP: **Yes / No**	**General Practitioner Name:**
Emergency Contact Full Name:	**General Practitioner Full Address & Contact Number:**
Emergency Contact Telephone Number:	

CONSENT		
Injectable Treatment	I have discussed:	- my medical history fully with my practitioner, including side effects of complications of my treatment relating to these conditions. - realistic expectations with my practitioner. - aftercare instructions with my practitioner to gain optimal results from my treatment.
	I understand that:	- results cannot be guaranteed and my practitioner will use their best judgement. - my practitioner has explained to me the use of, and indications, for the products I will be treated with. - I have been specifically informed of the following common injection related reactions: **redness, swelling, pain, itching, bruising and tenderness at the treatment site**. These reactions are mild to moderate and typically resolve within a few days. - repeat treatment will help to maintain the desired correction in the long term.
	I am aware that:	- the duration of effect of treatment can be shorter or longer than stated in an individual patient. - I have had the opportunity to have my questions answered.
Botulinum Toxin Treatment	I have been advised:	- by my practitioner of the expected outcomes and risks associated with this treatment.
	I understand that:	- potential side effects include: **feeling of heaviness in the forehead, change in eyebrow position, headache, eyelid swelling, eyelid droop, blurred vision, facial asymmetry, under or over treatment effect, double vision and infection.** - rare risks include; allergy (including anaphylaxis), flu-like symptoms, dry mouth, nausea, muscle twitching, muscle cramps, excessive muscle weakness and swallowing difficulty.
	I agree that:	- my practitioner has informed me that the effect of botulinum toxin treatment can last approximately **3 months on average.**
Dermal Filler Treatment	I have been advised:	- of the expected outcomes and risks associated with this treatment by my practitioner. - and discussed the realistic outcomes regarding the achievable aesthetic result. - of the potential risks, including: **pain, redness, bruising, infection, swelling and firmness at the treatment site, temporary lump or nodule, under or over treatment effect.**
	I understand that:	- rare risks include; allergy (including anaphylaxis), persistent lumps or nodules, abscesses, skin discolouration. - very rare risks include: skin necrosis, visual disturbance or blindness. - that depending on the product used, area treated, my skin type and the injection technique, the effect of dermal filler treatment can last from 3 – 12 months, as discussed with my practitioner. - in the event of an adverse event the practitioner has advised me to contact the clinic to seek further advice.

Consent to Medical Photography

It is necessary that you consent for your images to be taken for your medical records. Please sign below to confirm your consent to this.

*** Patient Signature:**

Additionally, please indicate below if you consent to your photographic images to be used for the following purposes:

Clinic website, social media platforms and marketing materials **Y | N**

Would you prefer your images to be anonymised **Y | N**

*** Patient Signature:**

PATIENT STATEMENT	
I am aware that:	- my practitioner has advised me of the amount of product required and the cost of the treatment, which I have already paid, or will pay immediately after treatment for any additional treatment received.
I agree that:	- I have read the above information fully and understand the complications that could occur. - I have had sufficient time for discussion with my practitioner and agree to treatment today. - the information that I have given is to the best of my knowledge correct. - my medical questionnaire is up to date and correct at the time of this treatment. - I am of the opinion that my request for treatment is for medical reasons. - I have expressed my thoughts and feelings to the treating doctor and consent to the treatment for the purpose of restoring and maintaining my health and my psychological well being. - **I hereby consent to the treatment.**
*** Patient Signature:**	

TREATMENT PLAN

Treating Clinician Name:	
Treatment Date:	
Treatment plan:	
Patient Signature (consent to treatment):	
Treating Clinician Signature:	

TREATMENT RECORD