INFORMED CONSENT FOR HYLAURONIDASE TREATMENT

THIS IS SAMPLE DOCUMENT. PLEASE EDIT TO MATCH YOUR OWN NEEDS. IT IS RECOMMENDED TO CONSULT AN ATTORNEY FOR LEGAL ADVICE.

PATIENT NAME:_____

DATE OF BIRTH:_____**PHONE**_____

PROVIDER'S NAME:_____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Hyaluronidase is an enzyme that breaks down dermal fillers made of hyaluronic acid into small sugars which easily disperse. **Initial** _____

RISKS OF INJECTION

Trauma during the procedure is caused by needles and cannulas passing through tissue, and includes bleeding, bruising, haematoma (a larger collection of blood in the skin, outside of blood vessels), damage to underlying structures including veins, arteries, nerves, salivary glands, lymph nodes, bone, muscle and other soft tissue structures are possible. In rare cases this could cause continuous problems in appearance, sensation or function and may require medical intervention to treat or may be permanent. Most traumatic injuries heal completely on their own. **Initial** _____

REACTIONS

Allergic reactions including anaphylactic shock are possible, they occur at a rate of between 1/2000 and 1/100 depending on the data source.

Anaphylactic shock has a mortality rate 0.3 to 5% depending on the study. An allergy test can often identify this risk prior to full exposure. Local reactions include oedema, erythema, pain and itching, urticaria and angioedema. **Initial** _____

SIDE EFFECTS

Hyaluronidase dissolves hyaluronic acid including molecules made by your body and previous treatments that you may wish to preserve could also be dissolved. You therefore could notice a reduction in skin elasticity and volume and associated asymmetry which typically would last a few days. It is common to cause bleeding, bruising, some swelling or oedema and redness near the injection site. **Initial** _____

TREATMENT FAILURE

It is possible that the procedure will fail to remedy the problem as often HA is not the sole cause of lumps, bumps or reactions. which may be caused by other materials. **Initial** _____

Complications from infection

There is a small risk of introducing an infection, and a theoretical risk that pre-existing infection could spread further if hyaluronidase is injected into the area, risking septicaemia though their are no recorded cases.

I confirm I do not have any known allergies to hyaluronidase, and to my knowledge I do not have any active cancers in the area injected and I am not pregnant or breastfeeding. **Initial** _____

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. I understand adjustments requiring more product incur a charge. **Initial** _____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial** _____

DISSATISFACTION

I understand that with all treatments the precise degree of improvement cannot be guaranteed. The outcome's subjective nature also means dissatisfaction is a possible outcome regardless of effectiveness of treatment. I understand that the effect of all treatments may gradually wear off, additional treatments may be necessary to acquire the desired effect, and further charges will apply if more product is required. **Initial** _____

AGREEMENT

By signing this form, you agree that you have read this form carefully and considered the side effects, risks and uncertainty of the outcome and decided the treatment is still in your best interests. You have discussed all the details of the treatment plan, past treatments and your medical history with your use of hyaluronidase. You understand that the initial treatment of side effects and complications is included in the cost of the procedure and therefore no refunds are issued due to any of the above occurring. You understand photographs are taken and stored for 7 years as part of my clinical record. **Initial** _____

Patient Name (Print)	Patient Signature	Date