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OCULOFACIAL PLASTIC, RECONSTRUCTIVE AND ORBITAL SURGERY

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Consent to Botulinum Toxin Treatment For Facial Wrinkles

Patient: _____ Age: _____

To the patient: You have the right to be informed about your condition and treatment so that you may make the decision whether or not to undergo the procedure, knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.

I have requested that Dr. Silkiss attempt to improve my facial wrinkles with Botox. This is the trademark for botulinum toxin. These injections have been used for more than two decades in children and adults to improve the problem of muscle spasm of the facial muscles. This toxin has also been useful to correct double vision due to muscle imbalance. This medication is FDA approved for the treatment of wrinkles. Injection of minute amounts weakens the muscle and prevents frowning, crow's feet, and expression lines. Botox causes weakness or paralysis of the muscle injected. Although the results are usually significant, I have been informed that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning expected results.

The Botox solution is injected with a small needle into the muscle. You may see the benefits develop over the next five to seven days; the benefits usually last for three to six months. Less frowning will be possible.

Reported side effects and complications have been minimal. Occasionally, slight swelling and/or bruising may occur and last for several days after the injections. Rarely, an adjacent muscle may be weakened for several weeks after an injection. This may lead to a minor, temporary droop of one or both eyelids. This may occur in approximately 1% of injections.

I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. I understand that several sessions may be needed to obtain the best result. I am not aware that I am pregnant or that I have any significant neurologic disease. .

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions.

_____ _____

Signed Date

_____

Name