

MD DIET/ SERENITY MD

CONSENT FOR JUVEDERM PROCEDURE

Patient's Name

Date of Birth

Date

Please initial each paragraph after reading. If you have any questions, please ask doctor BEFORE initializing.

Juvederm is a sterile, clear, colorless gel implant composed of natural occurring polysaccharide. It is indicated for injection deep into skin for correction of moderate to severe facial wrinkles and folds. The safety and efficacy of Juvederm for use in lip augmentation has not been established. Injection procedure reaction to Juvederm has been observed as consisting mainly of short-term inflammatory symptoms (redness) starting early after treatment and with less than 7 days duration.

You have the right to be informed about the proposed treatment so that you may make the decision whether or not to undergo the procedure after knowing the risks and complications. This disclosure is not meant to create anxiety, but is simply an effort to better inform you so that you may give or withhold your consent.

- _____ 1. As with all transcutaneous procedures, Juvederm implantation carries risk of infection.
- _____ 2. The safety of Juvederm for use during pregnancy, in breastfeeding females or in patients under 18 years of age has not been established. Please advise your doctor if there is a chance you might be pregnant.
- _____ 3. The safety of Juvederm in patients with increased susceptibility to keloid formation, hypertrophic scarring and pigmentation disorders has not been studied. Please advise your doctor if you have any of these disorders.
- _____ 4. Juvederm should be used with caution in patients on immunosuppressive therapy. Please inform your doctor if you are on immunosuppressive therapy.
- _____ 5. Patients who are using substances that can prolong bleeding, such as aspirin, non-steroidal anti-inflammatory drugs (Ibuprofen, Motrin, etc.) and warfarin (coumadin) may, as with any injection, experience increased bruising or bleeding at injection sites.
- _____ 6. Minimal exposure of the treated area to excessive sun and UV lamp exposure and extreme cold weather is required until any initial swelling and redness has resolved.
- _____ 7. If laser treatment, chemical peeling or any other procedure based on active dermal response is considered after treatment with Juvederm there is a possible risk of eliciting and inflammatory reaction at the implant site. This also applied if Juvederm is administered before the skin has healed completely after such a procedure. Please notify your doctor if you have recently undergone or are scheduled for such a procedure.
- _____ 8. Juvederm injections may include, but are not limited to the following: erythema, swelling, pain, bruising, lumps/bumps, tenderness, pruritus, and discoloration.
- _____ 9. Supplemental "touch-up" implantations may be required to achieve and maintain maximum correction.
- _____ 10. Topical or injectable anesthesia may be used to manage pain during and after injection.
- _____ 11. Within the first 24 hours, patients should avoid the following: strenuous exercise, extensive sun or heat exposure, and alcoholic beverages. Exposure to any of the above may cause temporary redness, swelling, and/or itching at the injection sides.
- _____ 12. Make-up may be applied a few hours post-treatment if no complications are present.
- _____ 13. Other: _____

I have fully and truthfully informed my doctor of my past medical and social history, including drug and alcohol use, recognizing that withholding information may jeopardize the planned outcome of this treatment. I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that any lack of cooperation can result in a less-than-optimal result. If any unforeseen condition should arise during this procedure calling for additional or different procedures from those planned, I authorize my doctor to use professional judgment to provide appropriate care to complete the procedure. I understand this is an elective procedure and have not been given any warranty or guarantee as to the result of the proposed procedure.

I certify I have had an opportunity to read the above paragraphs and I fully understand the terms used. I understand the reasons for the proposed treatment and potential benefits to me; it has been explained to me what alternatives there are, if any, to this treatment. All my questions have been answered to my satisfaction and I am willing to undergo this elective treatment. I also state that I read, speak and understand English.

Patient's Signature

Date

Witness' Signature

Date