Lot number: _____

Date: _____

Notes: _____

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Lot number: _____

Date: _____

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Lot number: _____

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Lot number: _____

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Date of preparation: January 2011 01/2011/AF/04

Juvéderm® ULTRA range of products
Treatment record

Consent and consultation form for patients treated with Juvéderm® ULTRA range of products

Patient name: _____

Date of birth: _____

Address: _____

_____

_____

_____

Contact numbers: _____

Email: _____

ALLERGAN

Medical history

Please complete the following medical questionnaire

Are you pregnant or breast feeding? Y ○ N ○

Have you a history of severe allergy/anaphylaxis? Y ○ N ○

Are you currently receiving any medical treatment? Y ○ N ○

If yes, please give more details _____

_____

Have you previously received any aesthetic treatments (e.g. laser, peels, dermabrasion etc.) Y ○ N ○

If yes, please give more details _____

_____

Have you had any treatment with dermal fillers, absorbable dermal fillers, semi-permanent dermal fillers or botulinum toxin? Y ○ N ○

If yes, which treatment did you receive, what areas were treated and when? _____

_____

_____

Have you ever suffered from auto-immune disease or disease affecting the immune system? Y ○ N ○

Do you have any cutaneous (skin) infection or inflammatory problems (e.g. herpes, acne etc.)? Y ○ N ○

Are you currently taking any steroids, aspirin or anticoagulant (e.g. warfarin etc.)? Y ○ N ○

Do you suffer from acute rheumatic fever or recurrent sore throat? Y ○ N ○

Do you suffer from any allergies, in particular allergies to hyaluronic acid, amide type local anaesthetics or lidocaine? Y ○ N ○

Do you suffer from untreated epilepsy? Y ○ N ○

Do you tend to develop hypertrophic scarring? Y ○ N ○

Do you suffer from porphyria? Y ○ N ○

Do you suffer from cardiac conduction disorders? Y ○ N ○

If yes, please give details: _____

_____

If the answer is yes to any of the above, your practitioner may ask for further details.
Treatment may be refused if it is not considered in your own interest to proceed.

Advised consent

I confirm I have been informed that:

The Juvéderm® ULTRA range of products are injected into the dermis to correct wrinkles, folds and lines of the face and skin or for lip augmentation. You should be aware that the combination of the Juvéderm® ULTRA range with certain drugs that reduce or inhibit hepatic metabolism (cimetidine, beta-blockers etc.) is inadvisable. You should be made aware that this product contains 0.3% of lidocaine that may produce a positive result in anti-doping tests. Due to the use of a needle, there is likely to be some bleeding at the injection site. Reactions giving rise to, for example, redness and swelling may occur after the injection and this may be associated with stinging, itching or discomfort upon pressure at the injection site. This reaction may last for several days. Rarely discolouration of the injection site, necrosis, abscess formation, granulomas, hypersensitivity and haematomas have been reported. Indurations or nodules may develop at the injection site.

If any of these symptoms persist for more than one week, or if any other side effects develop please report them to the practitioner as soon as possible so that they can advise on the best course of treatment. Whilst rare, such side-effects and their treatment may last for several months.

The aesthetic effects of the Juvéderm® ULTRA range of products last for up to 12 months but will vary depending on the condition of the skin, area treated, amount of product injected, injection technique and lifestyle factors such as sun exposure and smoking.

The average life of treatment in the lips is less than in other areas because of the high vascularisation and action of the lip area. A touch-up procedure may be required 1-3 weeks after the first injection and helps to optimise the results and maximise the duration of the results.

After treatment, please avoid extreme facial expressions, alcohol consumption and applying make up for 12 hours. Please avoid extreme sun exposure, UV light, freezing temperatures and saunas for 2 weeks after treatment.

My treating healthcare professional/aesthetic medical practitioner has:

- Provided me with sufficient information about the treatment detailed overleaf in order to make an informed decision
- Given me the opportunity to ask all remaining questions I may have about the treatment, and has answered them to the best of their ability
- Given me the time to consider the treatment detailed overleaf
- Received the relevant medical history information from me to the best of my knowledge

I therefore consent to receiving the described treatment by my treating healthcare professional/aesthetic medical practitioner.

Signed: _____ Date: _____