

# Botox® Hyperhidrosis Consent Form

To the patient: You have the right to be informed about your treatment so that you may make a decision to undergo the procedure, knowing the risks and hazards involved.

## I ACKNOWLEDGE:

- I have received a consultation with my aesthetic practitioner at [COMPANYNAME] and I consent to having Botox® treatment carried out upon myself for the improvement of underarm sweating.
- I have been informed about the treatment, procedure, indications, expected results and possible side effects. I understand that I may experience swelling, redness, tenderness, slight headache, pain and/or bruising that may occur for several days after my treatment, however these symptoms will resolve. Rarely an adjacent muscle may be weakened for several weeks after injection or my body may try to regulate itself by overcompensating sweat in other areas. I have been advised of the risks involved and the expected benefits of Botox® treatment.
- Although the results are usually dramatic 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 in my case.
- I agree to [COMPANYNAME] administering a local anaesthetic nerve block prior to treatment if necessary for pain relief.
- I am undergoing treatment of my own free will. I agree that no guarantee can be made as to the exact result of the procedure. I understand that whilst every precaution will be taken to prevent complications and that whilst complications from this procedure are rare, they can and sometimes do occur.
- I understand that complications may occur despite appropriate care and treatment.
- 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 to have any questions answered.
- I understand that the practice of medicine and surgery is not an exact science and therefore no guarantee can be given as to the results of the treatment referred to in this document. I accept and understand that the goal of this treatment is improvement, not perfection, and that there is no guarantee that anticipated results will be achieved

Patient First Name: \*: \_\_\_\_\_ Patient Last Name: \*: \_\_\_\_\_

Patient Signature \*

Date: \*: \_\_\_\_\_ dd / mm / yyyy Doctor First Name:: \_\_\_\_\_

Doctor Last Name:: \_\_\_\_\_

Doctor Signature

Date:: \_\_\_\_\_ dd / mm / yyyy