Dermal Filler Consent Form

To be completed before treatment. All sections are mandatory unless stated otherwise.

pabau

Patient Information

Full Name *

Date of Birth (DD/MM/YYYY) *

Address *

Contact Number *

Email Address

Emergency Contact (Name & Number) *

GP / Primary Care Provider

Medical History

Please answer all questions honestly. This information is essential for your safety.

Are you currently pregnant or breastfeeding? *

◯ Yes ◯ No ◯ Not sure

Do you have any autoimmune conditions (e.g. lupus, rheumatoid arthritis)? *

◯ Yes ◯ No

Do you have any bleeding disorders or take blood-thinning medication? *

◯ Yes ◯ No

Do you have a history of cold sores or facial herpes simplex? *

◯ Yes ◯ No

Have you ever had an allergic reaction to lidocaine or any anaesthetic? *

◯ Yes ◯ No ◯ Not sure

Have you had dermal filler treatment before? *

◯ Yes ◯ No

If yes to any of the above, please provide details:

Are you currently taking any of the following? (Select all that apply)

☐ Aspirin or NSAIDs (e.g. ibuprofen) ☐ Blood thinners (e.g. warfarin) ☐ Immunosuppressants ☐ Antibiotics

☐ Accutane / Isotretinoin ☐ Herbal supplements (e.g. fish oil, vitamin E, ginkgo) ☐ None of the above

List all current medications and supplements:

Known allergies (select all that apply):

- [ ] Hyaluronic acid
- [ ] Lidocaine / anaesthetics
- [ ] Latex
- [ ] Adhesive / plasters
- [ ] No known allergies
- [ ] Other (specify below)

Other allergies (if applicable):

Risks and Complications

Please read carefully. All treatments carry some level of risk.

¡ **Common side effects (expected):** Bruising, swelling, redness, tenderness, and mild asymmetry at the injection site. These typically resolve within 7 to 14 days.

¡ **Less common complications:** Infection, prolonged swelling, nodules or lumps, filler migration, allergic reaction, inflammatory reactions, and skin discolouration.

¡ **Rare but serious complications:** Vascular occlusion (blockage of blood vessels) which may lead to tissue necrosis (skin death) or, in extremely rare cases, partial or complete vision loss. These are medical emergencies requiring immediate treatment. Your practitioner is trained to recognise and manage these events.

¡ **Important:** No guarantee of specific results can be made. Individual outcomes vary based on anatomy, skin type, metabolism, and lifestyle factors. Additional treatments or touch-ups may be required to achieve desired results.

Consent Declarations

Please read each statement and tick the box to confirm your agreement.

- [ ] I confirm I have read and understood all the information provided about the proposed dermal filler treatment, including the expected outcomes, potential risks, and possible complications.
- [ ] I have had the opportunity to ask questions about the procedure, and all my questions have been answered to my satisfaction by my treating practitioner.
- [ ] I understand that results are not guaranteed, individual outcomes vary, and additional treatments may be required.
- [ ] I confirm that I have disclosed all relevant medical history, medications, allergies, and previous cosmetic treatments truthfully and completely.
- [ ] I understand the aftercare instructions and agree to follow them. I will contact the clinic immediately if I experience any concerning symptoms.
- [ ] I have been offered a cooling-off period and have had adequate time to consider my decision before proceeding.

Photograph Consent

I consent to clinical photographs being taken for my medical records: *

- ◯ Yes
- ◯ No

I consent to photographs being used for marketing, educational, or social media purposes (anonymised): *

- ◯ Yes
- ◯ No

Aftercare Acknowledgement

¡ **Post-treatment instructions:** Avoid touching or massaging the treated area for 6 hours. Avoid strenuous exercise, alcohol, and excessive heat (saunas, steam rooms) for 24 to 48 hours. Sleep elevated on the first night if possible. Apply cold compresses for swelling. Contact the clinic immediately if you experience increasing pain, white or blue skin discolouration, or vision changes.

☐ I confirm I have received and understood the aftercare instructions provided by my practitioner.

Patient Signature

Patient Signature

Print Name: _____ Date: ___/___/_____

Practitioner Details

Practitioner Name *

Qualifications / Registration Number *

Insurance Provider & Policy Number

Practitioner Signature

Print Name: _____ Date: ___/___/_____