

BOTULINUM HYPERHIDROSIS CONSENT FORM

Name:	Date of Birth:
Address:	Telephone:
Post Code:	
Date:	

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.

1. I _____ **[patients name]** have received a consultation with Dr Rajendra Patel and I consent to having Botulinum Injection treatment carried out upon myself for the improvement of _____ in the following area _____.
2. I understand that I am required have a follow-up consultation at 2 weeks, and that I am required to have photographs taken before, during and after treatment for my medical records.
3. I have been informed about the **treatment, procedure, indications, expected results and possible side effects.**
4. 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.
5. 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.
6. I have been advised of the **risks** involved and the expected benefits of **Botox® /Dysport®** treatment.
7. **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.**
8. I agree to the Dr Patel administering a local anaesthetic nerve block prior to treatment if necessary for pain relief.
9. I **accept responsibility for any complications that may occur and thereby absolve the St Mellion Clinic and any associated person of any blame resulting there from.**

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 agree that this constitute 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 terms of payment require full settlement on or before the day of my treatment.

Patient Signature _____ Date _____

Dr Rajendra Patel MB ChB LRCP LRCS Signature _____ Date _____