#

Save Face
Luxira Aesthetics

Hyperhidrosis Consent Form

**Patient Name:**

**Date of Birth:**

**Hyperhidrosis Informed Consent**

Botox® is indicated and licensed for the treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents. Its safety and efficacy have not been established for the treatment of hyperhidrosis on the hands, feet, scalp or face.

Botulinum toxin injection is generally a safe and effective treatment method. Nevertheless, certain side effects can occur;

**Common Side Effects Associated with the Injection Include**

* Pain or stinging sensation when the injection is performed.
* Localised swelling, redness, tenderness
* Bleeding at the sites of injection
* Bruising
* Numbness or itching of the area following injection.

The above usually resolve spontaneously within hours or days, but may persist for longer.

**Rare Side Effects (3-10%) Include**

* Compensatory sweating from other areas of the body.
* Aching or weakness in the upper arms, which is temporary
* Infection
* Pharyngitis
* Flu syndrome
* Headache
* Fever
* Anxiety
* Neck or back pain
* Allergic reactions have not been reported with this treatment; Symptoms of allergy include; itching, rash, red itchy welts, wheezing, asthma symptoms, dizziness or feeling faint. Get medical help immediately if you have any breathing problems.
* Weakness of hand muscles and drooping of the eye lids may occur in patients who receive BOTOX ® for palmar hyperhidrosis and facial hyperhidrosis, respectively.

In general, adverse reactions occur within the first week following injection and while generally temporary, may have a duration of several months, or longer.

Successful treatment can significantly reduce sweating in the treatment area for a period of 6-12 months. The successful outcome varies by degree and how long it lasts from one individual to another and cannot be guaranteed. Treatment may be repeated once the therapeutic effect has worn off.

**Alternative Treatments I have been advised I may Consider; Acceptance of my Present Condition, Prescription Anti-Perspirants, Iontophoresis, Laser Ablation, Miradry,**

**Material Information**

* I understand that though complications are uncommon, they do sometimes occur. It is possible that side effects not described may occur and indeed that a complication not previously reported may occur for the first time.
* I understand if I suffer any adverse reactions that are not expected, or concern me, I must contact the clinic. An appointment will be made for me to be seen. The clinic cannot take responsibility for complications or results that have not been reported, assessed, documented and managed in a timely fashion.
* I understand that whilst results desired and expected have been discussed, outcomes vary between individuals and cannot be guaranteed.
* I confirm that the medical health history form has been completed truthfully and I am fully aware that withholding medical information, including history of previous treatment, may be detrimental to the safe and optimal outcome of any treatment administered. If there are any changes in my medical history, I must inform the practitioner.
* I confirm that I have been provided with verbal and written information about this treatment which includes aftercare and follow up advice.
* I agree to follow the aftercare advice and understand this reduces risk of adverse reactions and helps ensure optimum results.

The main reason for this treatment is-

* For physical benefit, personal & psychological reasons



* I understand information about me will be treated as confidential and access to it restricted in accordance with the Data Protection Act, unless specific permissions given.
* I consent to my medical records being shared with appropriate medical professionals
* I understand photographs are taken as part of my medical record.

**On occasion it is helpful to share visual images of our own treatment results.**

**I consent to photographs being published for;**

* + Educational and training purposes with medical professionals
	+ Educational purposes with selected patients during consultation
	+ Educational/promotional purposes in the clinics portfolio viewed by selected members of the public
	+ Educational/promotional purposes on the clinic website
	+ Educational purposes for selected public events
	+ I understand that no fee is payable to me or any other person in respect of the material either now or at any time in the future.
	+ I confirm that the purpose for which the material would be used has been explained to me in terms which I have understood.



* I accept the clinic terms and conditions. I am satisfied treatment with botulinum toxin has been explained comprehensively and that the possible risks and side effects associated with the treatment have been fully discussed and understood. I have taken sufficient time to process and consider the information provided and any questions I had have been answered to my satisfaction, before making a decision to proceed with the agreed treatment plan.

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioners Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: Dr P Davis Date: \_\_\_\_\_\_\_\_\_\_\_\_\_