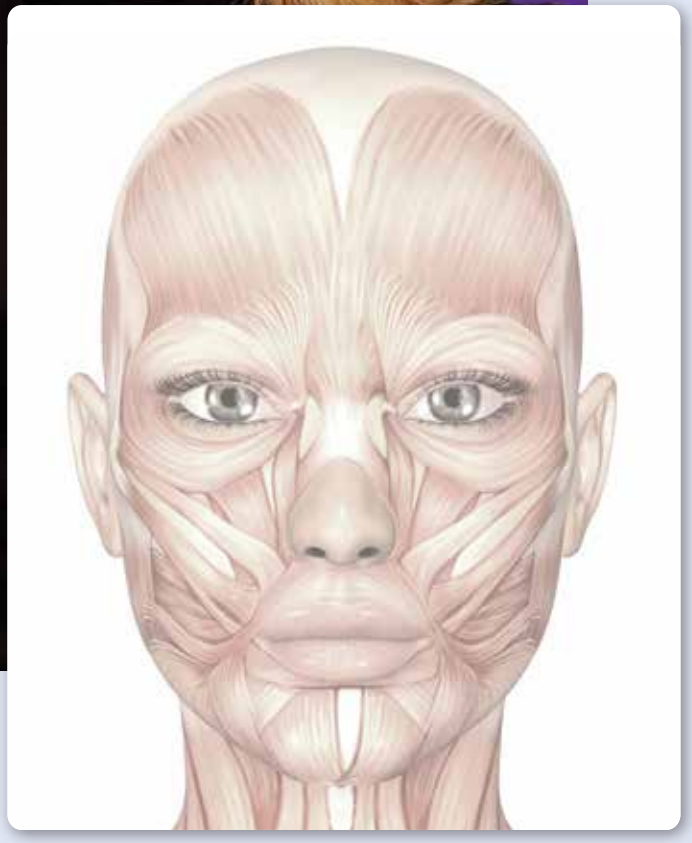
BOTOX® Lot number:



QUOTATION

Date (quote valid until): _____

Consultation (if applicable): _____

_____

Procedure: _____

_____

BOTOX® units: _____

Date (quote valid until): _____

Consumables: _____

TOTAL (incl VAT): R

BOTOX® Botulinum Toxin Type A

Allergan

BOTOX® INFORMED CONSENT

Please request a copy of this consent form from your medical doctor

Date: _____

Patient name: _____

Age/year of birth: _____

Contact numbers: _____

Email: _____

Notes: _____

_____

This form is only to be used when Botulinum toxin type A (BOTOX®) is used, and not for any other product. This form pertains to the specific nature, conditions, use, risks and warnings associated with BOTOX® and cannot be used interchangeably with another product.

MEDICAL HISTORY

Please complete the following medical questionnaire:

The answers to these questions are important for your health care and the appropriateness of the choices available to you. It will affect the information, instructions and warnings the doctor will provide you, and may affect the treatment choices available to you and in some cases it may be in your best interest not proceed with treatment. If you tick "yes" anywhere below, it is important that you provide further information in the space below:

Are you pregnant or breastfeeding? Y ○ N ○

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

Have you previously received any aesthetic treatments (i.e. laser, peels, dermabrasion etc.) If yes, please give more details (i.e. areas treated and products used): Y ○ N ○

_____

_____

Have you previously received any treatment with dermal fillers or botulinum toxin? If yes, which treatment did you receive and what areas were treated and when? Y ○ N ○

_____

Are you currently receiving any medical treatment? If yes, please give details: Y ○ N ○

_____

Are you currently taking any dietary supplements or other medications? If yes, please note them: Y ○ N ○

_____

Have you ever been admitted to hospital? If yes, please give details: Y ○ N ○

_____

Have you had any previous surgery? If yes, please give details: Y ○ N ○

_____

Do you suffer from any allergies? If yes, please give details: Y ○ N ○

_____

Have you suffered from any of the following?

Heart disease/angina (severe pain in chest)	Y ○ N ○	Bell's/facial palsy	Y ○ N ○
Auto-immune disease (e.g lupus, arthritis etc)	Y ○ N ○	Skin disease (e.g. herpes or acne)	Y ○ N ○
Convulsions (seizures)	Y ○ N ○	HIV/hepatitis	Y ○ N ○
		Phlebitis (inflammation of blood vessel walls)	Y ○ N ○

Treatment may be refused if it is not considered in your best interest to proceed.

PRECARE

(Before treatment)

One week prior to your BOTOX® treatment, we advise you to avoid using alcohol, garlic, and/or aspirin, or any other non-steroidal anti-inflammatory drugs for pain, swelling and/or fever, such as medicines containing diclofenac, mefenamic acid, indometacin or ibuprofen - ask your doctor or pharmacist whether your medication includes any of these ingredients. Following these instructions will reduce the risk of bruising or bleeding at the point of injection.

If this is your first visit, you will need to provide your medical doctor with information on your medical history and any current problems, as well as details of any allergies you have or medications you are taking. There is no need for an allergy test, unless your medical practitioner feels it's necessary.

POSTCARE

(After treatment)

The aesthetic effects of BOTOX® last for an average of 3-4 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. Results of your treatment may take up to 14 days to take full effect.

After treatment:

- For 4 hours - do not lie down or do "strenuous" exercise and similar activities, nor should you do anything that increases the blood flow to the injection area
- For 12 hours - avoid extreme facial expressions, alcohol consumption, and applying make-up
- For 24 hours - do not rub or massage the treated areas as this could influence the effect of the product
- For 2 weeks - avoid direct sun exposure, UV light, freezing temperatures and saunas. Tiny bumps or marks will go away within a few hours after your treatment.

Please consult with your medical doctor if further treatment is required.

INFORMED CONSENT

I confirm I have been informed that:

BOTOX® is approved for the treatment of glabellar lines (frown lines between the eyebrows) and lateral canthal lines (crow's feet lines), and is injected into the skin to help correct wrinkles. Possible things that could happen when, or after, the product is used, if they occur, usually appear within the first few days following injection, and are usually temporary and mild to moderate in severity. As with any prescription medicines, BOTOX® can cause side effects and your doctor will advise you about these in more detail. The most common side effects associated with the use of BOTOX® are headaches, ptosis (drooping of the upper eyelid), redness, localised muscle weakness and face pain. As with any injection, pain, burning, stinging, swelling and/or bruising may occur. Patients treated with recommended doses of BOTOX® may experience complete muscle weakness.

BOTOX® should only be administered by medically qualified doctors with appropriate qualifications and expertise in this treatment and who have the required equipment.

If you are worried about any side effect you think you may be experiencing, or the duration thereof, contact your doctor as soon as possible to discuss this and to obtain medical advice or treatment if needed. Side effects possibly related to the spread of toxin distant from the site of administration have been reported very rarely with botulinum toxin (e.g. exaggerated weakness in other muscles in your body not near to where the injection was given, difficulty in swallowing or pneumonia due to unwanted food or liquid in the airways, which can be fatal). A severe allergic reaction may occur very rarely after injection of BOTOX®. If you experience any of the above, contact your medical doctor immediately to obtain medical advice and/or attention.

Injection of BOTOX® is not recommended in patients with a history of dysphagia (difficulty in swallowing). Contact your medical doctor and seek medical attention immediately if you develop breathing, swallowing, or speech difficulty.

Too frequent or excessive dosing of BOTOX® may increase the risk of antibodies in the blood which may lead to failure of treatment with botulinum toxin when used for this and other conditions. The aesthetic effects of BOTOX® last for an average of 3-4 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.
After treatment, please avoid extreme facial expressions, alcohol consumption and applying make up for 12 hours. Please avoid sun exposure, UV light, freezing temperatures and saunas for 2 weeks after treatment.

My medical doctor has:

- Explained to me what my health status is, and how the treatment I have chosen may affect my health
- Provided me with sufficient information about the treatment detailed overleaf in order to make an informed decision
- Provided me with treatment options generally available, the benefits, risks and costs associated with each, and I have freely chosen this treatment.
- Provided me with information on the risks associated with the treatment, including the side-effects outlined in this document
- Provided me with instructions as to what my responsibilities are before, and after the treatment, and what I should, or should not do, including the instructions outlined in this document
- 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 and I am satisfied with the answers I have received
- Given me the time to consider the treatment detailed overleaf
- Received the relevant medical history information from me and my signature on this form indicates my informed consent to the treatment and my acceptance of the conditions outlined by my doctor and in this document

I understand that I can withdraw this consent at any stage prior to the commencement of treatment, and that any subsequent decision relating to refusal of continued treatment, including top-ups, will have an effect on the achievement of the treatment. I therefore consent to receiving the described treatment by my medical doctor.

I agree for my doctor to use pictures before and after my treatment for (Please tick the following boxes if you do agree):
○ Educational/Training purposes ○ To manage my expectation/outcomes

Signed: _____ Date: _____