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## Dermal Fillers Medical History Treatment Record

Full Name:			
Age:	DOB:	Height:	Weight:
Address:			
		Postcode:	
Mobile:		Home Tel:	
Email:			
Allergies:			
Non Smoker:	Ex Smoker:	Smoker:	Cigarettes per day:
Alcohol unit consumption per week:			
Medical conditions past and present;			
What medications are you currently taking?			
Are you pregnant or lactating currently?			
Any previous operations?			
Previous cosmetic procedures?			
Current skin care regime:			
Have you had the Covid19 vaccine?		1st dose date:	2nd dose date:

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health, I will report it to Needle Nurse Aesthetics as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and I will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### INFORMED CONSENT FOR TREATMENT WITH DERMAL FILLERS

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

### THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

Initial: \_\_\_\_\_

### RISKS & COMPLICATIONS

Before undergoing this procedure, understanding the risks are essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalisation, and/or extended outpatient therapy to permit adequate treatment: It has been explained to me that the risks include but are not limited to: 1) Post treatment discomfort and pain, swelling, redness, bruising, and discolouration of skin; 2) Post treatment infection; 3) Allergic reactions; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma (delayed reaction and lump) formation; 7) Localised skin or tissue loss and necrosis due to blockage of a blood vessel by injected product, and/or sloughing, with scab and/or without scab and 8) asymmetry.

Initial: \_\_\_\_\_

### PREGNANCY & ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

Initial: \_\_\_\_\_

### ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

Initial: \_\_\_\_\_

### PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected before receiving treatment.

Initial: \_\_\_\_\_

### RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

Initial: \_\_\_\_\_

I hereby indemnify Needle Nurse Aesthetics from any liability relating to the procedures that I have volunteered for. I also understand that any treatment performed is between me and the nurse provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician.

Initial: \_\_\_\_\_

### PUBLICITY MATERIALS

I authorise the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. During procedures given at Needle Nurse Aesthetics, I understand that photographs and videos may be taken of me for educational and marketing purposes. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Initial: \_\_\_\_\_

### RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 12 months. Most patients are pleased with the results of dermal fillers use. However, like any aesthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear sufficiently, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment

Initial: \_\_\_\_\_

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me and I also understand that any treatment performed is between me and the nurse provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read this form and understand it.

Initial: \_\_\_\_\_

The Dermal Filler treatment I am receiving is:

My questions have been answered satisfactorily. I accept the risks and complications of the procedure. I certify that if I have any changes occurring in my medical history, I will notify Needle Nurse Aesthetics Immediately.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

For the treating professional: I am the nurse healthcare professional. The patient has had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact Needle Nurse Aesthetics should they have any questions or concerns after treatment.

Signature: \_\_\_\_\_

Print name \_\_\_\_\_ Date: \_\_\_\_\_

I am satisfied with the results of the treatment (or re-treatment/correction if applicable) that I have received today. I have had the opportunity to ask questions and review my results personally through photos taken and mirror reflection.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_