FAMILY PRACTICE SPECIALISTS

PATIENT PRE AND POST TREATMENT INSTRUCTIONS FOR RESTYLANE/PERLANE ®

Recommendations for a few simple guidelines both pre and post-procedure. These can make the difference between a good result and a fantastic one.

Pre Treatment Instructions

- One week before exclude: Aspirin (Advil, Aleve, etc.), Gingko Biloba, garlic, flax oil, cod liver oil, vitamin A, vitamin E and any other essential fatty acids.
- 24 to 48 hours before, exclude: Niacin, high-sodium foods, high sugar foods, refined carbohydrates (you may eat fruit; just avoid foods with added sugar, fructose, corn syrup, etc.) spicy foods, caffeine, alcohol, cigarettes.
- Avoid Chemical Peels and Laser 1-2 weeks prior to dermal filler treatment.

Post Treatment instructions

- Immediately after your procedure and for 24 hours you should avoid the following:
    - Strenuous Exercise
    - Sun exposure/heat exposure/tanning beds
    - Alcoholic Beverages
    - Massaging/pressing areas treated
    - Extreme cold temperatures
- 48 hours after your procedure you may begin adding gingko Biloba, garlic, flax oil, flax oil, cod liver oil, vitamin A, vitamin E, or any other essential fatty acids
- 3 days to a week after your procedure, depending on our sensitivity level, you may add: higher-sodium foods, high sugar foods, refined carbohydrates (you may eat fruit; just avoid foods with added sugar, fructose, corn syrup, etc.) caffeine, alcohol, cigarettes, flush-free niacin, aspirin, and spicy foods.
- If Laser treatment, Chemical Peel or any other procedure is considered after dermal filler treatment, the risk of eliciting an inflammatory process may be possible. Consider such treatments 1 week before and/or after filler treatment.

RESTYLANE/PERLANE®
(HYALURONIC ACID)

FAMILY PRACTICE SPECIALISTS
CONSENT FORM

BRIEF MEDICAL HISTORY

Name________________________________Phone______________Age____
Address_____________________________City/State____________________Zip_______

MEDICATIONS: ____
ALLERGIES: ______________________________ Women: Are you Pregnant or Lactating? ___________
Medical Problems:____

Check ☑ any of the following history you have or have had in the past:

❑ History of Anaphylaxis	❑ Multiple Severe Allergies	❑ Facial Acne	❑ Facial Rashes	❑ Hives
❑ Herpes	❑ Active Inflammatory process	❑ Infection (at proposed injection sites)	❑ Autoimmune Disease	❑ Immunosuppressive Therapy

In the past week have you taken:

Medications: □ Aspirin □NSAIDS (Advil, Aleve, Celebrex) □Anticoagulants □Steroids
Supplements: □GinkoBiloba □Vitamin A □Vitamin E □Garlic □Omega-3

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 the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

RESTYLANE/PERLANE® ADMINISTRATION CONSENT

Restylane® is a gel of hyaluronic acid generated by streptococcus species of bacteria, chemically cross linked with BDDE, stabilized and suspended in physiologic buffer at PH=7 and concentration of 20 mg/ml. areas most frequently treated are: nasolabial folds, oral commissures, lips, and glabellar. Client may experience a slight burning sensation during injections. The procedure takes about 20-30 minutes. Results last approximately six months.

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, and bruising; 2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment; 3) Allergic reaction.

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

PREGNANCY, ALLERGIES

I am not aware that I am pregnant, have any significant Medical diseases, or have any severe allergies.

PAYMENT

I understand that this procedure is cosmetic and that payment is my responsibility.

I hereby voluntarily consent to treatment with Restylane/Perlane® injection for the condition known as: Facial Static Wrinkles. The procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

______________________ __________ ____________________________ __________
Patient Signature Date Witness Signature Date

FAMILY PRACTICE SPECIALISTS

I ___________________________ understand that a Dental Infiltrate will be performed to provide temporary relief of discomfort associated with the administration of Resylane. I understand that Dental Infiltrates are not 100% effective but should reduce pain in most cases.

The risks of a Dental Infiltrate include bleeding, infection, and adverse reaction to the anesthetic.

_____(Initial) I do not have any hypersensitivity to any local anesthetic agents, nor do I have a history of malignant hyperthermia.

I have read and understand this consent and all of my questions have been addressed and answered to my satisfaction. I have no contraindicating factors, and thereby grant permission for a Dental Infiltrate. I certify that if any changes occur in my medical history/health or regime, that I will notify this office as soon as possible.

____

Client (Print Name) (Signature) Date

____

Witness (Print Name (Signature) Date