



## CONSENT FORM FOR BOTULINUM PROTEIN

Indications and alternatives Botulinum toxin type A, a neurotoxin that blocks messages between muscles and the nerves that control them. The effects of Botox become apparent 2-5 days after injection and generally last for 4-6 months. The FDA has approved the use of Botox to treat facial dystonias (spasms), strabismus (crossed eyes), and to temporarily soften facial rhytids (wrinkles) between the eyebrows. While the FDA has not approved injections to improve the appearance of wrinkles in other areas of the face, physicians may perform these “off-label” procedures. There are alternatives to Botox, including no treatment, or medicines or surgery on my facial nerves and muscles.

It is advisable to avoid aspirin or non-steroidal anti-inflammatory medications one week prior to treatment and three days after treatment.

Side effects and complications include but are not limited to:

1. Bruising
2. Undercorrection (not enough effect) or overcorrection (too much effect)
3. Facial asymmetry (one side looks different than the other)
4. Paralysis of a nearby muscle leading to: droopy eyelid, double vision, inability to close eye, difficulty whistling or drinking from a straw
5. Generalized weakness
6. Permanent loss of muscle tone with repeated injection
7. Flu-like syndrome or respiratory infection
8. Nausea or headache
9. Development of antibodies to Botox
10. Botox contains human-derived albumin and carries a theoretic risk of virus transmission. There have been no reports of disease transmission through Botox.

Contraindications You should not have Botox if: you are **pregnant; nursing;** allergic to albumin; have an infection, skin condition, or muscle weakness at the site of the injection; or have Eaton-Lambert syndrome, Lou Gehrig’s disease, or myasthenia gravis.

I understand the above, and have had the risks, benefits, and alternatives explained to me. No guarantees about results have been made. I give my informed consent for Botox injections today as well as future treatments as needed.

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Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

I have explained the risks, benefits and alternatives to surgery and the patient has consented to the above.

Yogita Kashyap, MD  
Physician

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date