DERMATOLOGY
ASSOCIATES OF ITHACA
Healthier Skin Since 1983

DID YOU KNOW?

Wrinkles result from a combination of many factors. It's not just about cellular changes that can occur over time, reduction of collagen, or damage caused by free radicals in the sun and environment.

BOTOX® works by blocking nerve impulses to the injected muscles.

Ithaca: 1051 Craft Rd
Cortland: 3773 Luker Rd.
T: 607-257-1107
F: 607-257-0369
www.ithacaderm.com

BOTOX®

BOTOX® Cosmetics is a prescription medication used to target the underlying causes of wrinkles, frown lines and crow's feet – the repeated muscle contractions from frowning and squinting over the years. BOTOX® is injected into these muscles to temporarily reduce muscle activity, leading to a reduction in the appearance of wrinkles, crow's feet and frown lines. Typically, the muscle action will return in 3-5 months.

PROCEDURE DESCRIPTION

Each treatment takes approximately 15 minutes. Your provider will ask you to make expressions to locate the areas of injection. Ice is applied to each site prior to injection to minimize discomfort.

RISK/ COMPLICATIONS

Immediate redness, swelling and bruising may occur at each injection site. Substances that increase bruising include Vitamin E, aspirin, Motrin and other non-steroidal anti-inflammatory drugs.

Possible side effects include: transient headache, swelling, bruising, pain during injection, twitching, itching, numbness, asymmetry (unevenness), temporary drooping of eyelids or eyebrows. These side effects are rare, but have been reported.

Cold sores can be triggered by any facial procedure. If you have a history of cold sores, be sure to notify your provider prior to your procedure so you can be given medication to reduce the chance of a breakout.

There is no guarantee of results, and though it is unlikely, there may be minimal or no improvement of the condition. In a very small number of individuals, the injection does not work.

CONTRAINDICATIONS

- □ Pregnancy
- □ Nursing
- □ History of diseases of muscles and nerves, such as ALS, Lou Gehrig's disease, myasthenia gravis or Lambert-Eaton syndrome.

BEFORE Your Botox® treatment

- **Aspirin and ibuprofen should be avoided 10-14 days prior** to minimize risk of bruising. **If you have been told to take aspirin daily by your doctor, please let us know before stopping it.** Other medications to avoid include **Excedrin™, Motrin™, Naprosyn™, Aleve™, Gingko, garlic supplements, fish oil, and Vitamin E.**
- **Avoid alcohol 2 days prior to treatment** to minimize risk of bruising.
- If you have a history of **cold sores**, please let us know before the day of the procedure so a medication can be given to reduce an outbreak.
- Be sure that you have communicated any pertinent medical history to your provider, particularly any history of neurologic or muscular disease, medication allergies, new medications, pregnancy, breastfeeding, and previous cosmetic procedures.

AFTER Your Botox® treatment

- **Aspirin and ibuprofen should be avoided for 2 days after** to minimize risk of bruising.
- Immediately after the procedure you can reapply makeup and resume your skin care routine.
- Avoid massaging the areas, lying down, or bending for the next 4 hours.
- Use the treated muscles by making facial expressions over the next few hours to maximize your results.
- The full effect of the treatment is seen in about 2 week after the procedure.
- We would like to follow up with you 2 weeks post treatment to make sure you are pleased with the results.

CONSENT TO YOUR BOTOX® TREATMENT

Patient Name: _____

DOB: _____

1. I consent to the performance of BOTOX® Cosmetic or Xeomin® within one year of date of this consent; to be performed by Dr. Josephine McAllister.
2. The procedure has been explained to me including the benefits of the treatment, risks involved, and possible alternative methods of treatment. I have had the opportunity to discuss this procedure and received answers to all questions I asked. _____ (initial)
3. I understand that there is no guarantee that any particular results will be obtained.
4. I authorize the taking of clinical photographs to assess the effect of treatment and for possible use for marketing, patient education and scientific purposes. I understand my identity will be protected.

I have read the above and understand it. My questions have been answered satisfactorily by the doctor and doctor's associates. I accept the instructions, risks and complications of the procedure.

_____

Patient Signature Date

Consent form based on literature from Dermatology and Aesthetics of Wicker Park. Rev. 5/1/14.