Grandview Aesthetic Medicine
833 Grandview Avenue
Columbus, Ohio 43215
(P) 614-437-9002; (F) 614-336-8557

Dermal Fillers: Consent Form

We use a sterile gel consisting of non-animal, stabilized hyaluronic acid for injection into the skin to correct facial lines, wrinkles and folds, for lip enhancement and for shaping facial contours. (Restylane, Juvederm).

The use and indication for the above product has been explained to me by my practitioner, and I have had the opportunity to have all questions answered to my satisfaction. I have been specifically informed of the following: after injection, some common injection related reactions may occur, (bleeding, bruising, infection, swelling, redness, pain, discoloration, and tenderness at the injection sight). They typically resolve spontaneously within one to two days after injection into the skin and within one week after injections to the lips. Other types of reactions are rare, but about 1 in 2,000 treated patients have experienced localized reactions thought to be of a hypersensitivity nature. These have usually consisted of swelling at the injection site, sometimes affecting surrounding tissues. Redness, tenderness and rarely, acne-like formations have also been reported. These reactions have either started a few days after injection or after a delay of two or four weeks and have been described as mild to moderate and self-limiting, with an average duration of two weeks.

My practitioner has also informed me that depending on the area treated, skin type, and injection technique, the effect with Hyaluronic products can last six months or longer, (lips: approximately four to six months), but that in some cases the duration of the effect can be shorter or even longer. Touch up and follow up treatment helps sustain the desired degree of correction.

I have answered the questions regarding my medical history to the best of my knowledge. I agree to contact Grandview Aesthetic Medicine immediately with any prolonged swelling, pain, drainage, or problems at the injection sites. I also agree to follow all post procedure instructions and take any course of antibiotic/antiviral medications recommended. I consent to taking pictures before and/or after the procedure to help document progress. I will allow their use for scientific, educational, or research purposes as deemed appropriate by Dr. Shawn Bailey and Kayla Decaminada, CNP as long as my name and identity are protected.

PRINT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____ DATE: _____

I certify that I have explained the nature, purpose, benefits, risks, complications and alternatives of the proposed procedure to the patient. I have answered fully, and I believe that the patient fully understands what I have explained.

NURSE SIGNATURE: _____ DATE: _____