**LA NOUVELLE MEDICAL SPA ~ DR. ANTOINE HANNA**

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**INJECTION CONSENT FOR: BOTOX/JEUVEAU/ XEOMIN**

If you have any questions, please ask your doctor BEFORE signing.

**BOTOX/JEUVEAU/XEOMIN** is a substance originally used for treating muscular disorders of the eye, but has also been found useful as a reversible muscle relaxant. As such, it may be used to temporarily relax certain facial muscles, thus having a cosmetic effect by smoothing certain facial wrinkles (“Crow’s feet” and other lines of expression).

**Before the procedure.**  You’ll probably be seated in a reclining chair, much like you find in a dentist office. No anesthesia is required, although your doctor may choose to numb the area with a cold pack or anesthetic cream.

**The procedure.** Your doctor will determine where to administer the injections by examining your ability to move certain muscles in your brow area. The entire procedure takes approximately 10-15 minutes.

**After the procedure.** There’s no recovery time needed. You’re ready to get on with your day! The most common side effects follows injections include temporary eyelid droop and nausea. Localized pain, infections, inflammation, tenderness, swelling, redness, and/or bleeding/bruising may be associated with the injection. Patients with certain neuromuscular disorders such as ALS, myasthenia gravis, or Lambert-Eaton syndrome may be at increased risk of serious side effects.

**Seeing results.** The effect of **BOTOX/JEUVEAU/XEOMIN** begins in a few days and lasts for up to 3 months, at which time retreatment is necessary to gain a similar muscle relaxant effect. Occasionally, “touch-up” injections may be required for full effect.

**Results may vary, therefore no promises or guarantees given by this treatment.**

**I hereby consent to the treatment with BOTOX/JEUVEAU/XEOMIN. The procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risk and complications of the procedure.**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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