



Heather J. Roberts, M.D.
A Medical Corporation

Dermatology & Dermatologic Surgery
Cosmetic & Laser Surgery

Diplomate, American Board of Dermatology
Fellow, American Academy of Dermatology
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The American Society for Laser Medicine and Surgery
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COSMODERM/COSMOPLAST CONSENT FOR TREATMENT

I, _____, authorize Heather J. Roberts, M.D. or _____, MD to inject Cosmoderm and/or Cosmoplast into wrinkles, scars, contour defects and/or lips.

I understand that Cosmoderm/Cosmoplast implants must not be injected in patients with:

- A) Severe allergies manifested by a history of anaphylaxis
- B) Known allergies to lidocaine anesthesia

I agree to inform Dr. Roberts of any such history prior to injection so alternative treatments can be arranged. Initial _____

I am aware that Cosmoderm/Cosmoplast implants contain sterile, highly purified human-based collagen derived from human fibroblast cell culture.

I understand Cosmoderm/Cosmoplast collagen has been extensively tested for viruses and other potentially infectious and cancer causing agents. Initial _____

I am not currently taking immune suppressing medications. Initial _____

I understand the following warnings:

- A) Although rare, when injecting wrinkles around the eyes, between the brows or forehead, accidental injection of Cosmoderm/Cosmoplast into blood vessels could result in temporary or permanent visual disturbances, blindness, skin ulceration and sloughing with resultant scarring.
- B) The relationship of connective tissue diseases like rheumatoid arthritis, systemic lupus erythematosus, polymyositis and dermatomyositis to human collagen injections has not been determined.
- C) The safety of Cosmoderm/Cosmoplast use in patients with known allergy to bovine collagen has not been studied.
- D) As with all skin injections, Cosmoderm/Cosmoplast collagen implant carries a risk of infection.
- E) Cosmoderm/Cosmoplast will not be injected into areas of active infection or inflammation (ex. pimples, cysts, rashes or hives) until such resolve.
- F) I have been advised, when appropriate, not to take blood thinners (Aspirin, Advil, Vitamin E, Fish Oil, Gingko, Garlic, Motrin etc.) for 2 weeks before treatment, to decrease the risk of bruising or bleeding at injection sites. If bruising occurs, it may last up to 1 – 2 weeks. Application of vitamin K cream (available in our office for purchase) may speed healing.

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(Continued)

- G) Temporary mild swelling, redness and discomfort may occur at the implant site immediately following injection. Resolution is usually spontaneous within 1 – 2 days.
- H) Reactivation of pre-existing herpes simplex infection may occur at collagen injection sites. I will notify Dr. Roberts of any such history prior to injection so that I may be given antiviral medication. Initial_____

I understand that if I develop increasing discomfort or swelling, itch or spreading redness, I will immediately call Dr. Roberts. Initial_____

I understand that Cosmoderm/Cosmoplast are FDA approved temporary fillers that will require periodic "touch-up" to maintain maximum correction.

I agree that during the first 24 hours following injection, I will avoid:

- A) Strenuous exercise
- B) Alcoholic beverages
- C) Extensive sun or heat exposure

I understand that exposure to A) – C) may cause prolonged redness, swelling and/or itching at injection sites.

I understand that the safety of Cosmoderm/Cosmoplast injections during pregnancy is unknown. I am not aware that I am currently pregnant. Initial_____

I have read the "Cosmoderm/Cosmoplast Consent For Treatment" in its entirety and have discussed the risks, benefits and alternatives of injectable human collagen with Dr. Roberts or _____ Initial_____

I understand this procedure is considered cosmetic and further understand that it will not be covered by my health insurance. Payment in full is due on the day of service. My insurance may or may not cover the cost of treatment if any complications should arise. Initial_____

I understand the information provided above. All of my questions have been answered to their fullest and I wish to proceed with treatment.

Patient Signature_____ Date_____

Guardian Signature(if patient is a minor)_____

Relationship to patient_____

Witness Signature_____ Date_____