



Heather J. Roberts, M.D.

A Medical Corporation

Dermatology & Dermatologic Surgery
Cosmetic & Laser Surgery

Diplomate, American Board of Dermatology
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Restylane / Restylane Fine Line / Perlane Consent For Treatment

I, _____, authorize Heather J. Roberts, M.D. or _____ MD to inject Restylane / Restylane Fine Line and/or Perlane into wrinkles, scars, contour defects and/or lips.

Description: Restylane is a hyaluronic acid gel produced in a lab from bacterial capsular sources.

Indication: Restylane is FDA approved for the treatment of moderate to severe facial wrinkles and folds.

I understand the following warnings:

- 1) Restylane is contraindicated for patients with severe allergies manifested by difficulty breathing, swelling of the lips, tongue or throat.
- 2) Restylane contains trace amounts of bacterial proteins and is contraindicated in patients with a history of allergies to such material.
- 3) Although rare, when injecting wrinkles around and between the eyes accidental injection of Restylane in blood vessels may cause temporary or permanent visual disturbances, blindness, skin ulcerations and sloughing with resultant scarring.
- 4) Restylane will not be injected into sites of active infection or inflammation (rashes, cysts, pimples or hives) until such resolve.
- 5) Allergic reactions to Restylane have been observed with swelling, redness, tenderness, and rarely acne-like bumps.
- 6) Temporary injection site reactions including redness, warmth, bruising, swelling and discomfort have been observed but usually resolve spontaneously within 7 days.
- 7) As with all injections, Restylane treatment carries a risk of infection.
- 8) I have been advised that Restylane should be used with caution in patients with known keloid scar formation (ie raised, enlarged scars). To my knowledge, I have no history of keloids. Initial_____
- 9) I have been advised when appropriate not to take blood thinners (aspirin, Advil, Vitamin E, Fish Oil, Ginko, Garlic, 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.
- 10) Reactivation of pre-existing cold sores may occur at injection sites. I will notify Dr. Roberts of any such history prior to injection so that I may be given antiviral medication. Initial_____

To alleviate discomfort during the procedure, I may use topical anesthetic cream, injections of local anesthesia and possibly even a dental nerve block. I have been advised there may be minor temporary adverse effects from injectable anesthesia and/or nerve block such as numbness, swelling, hematoma, bruising, accidental biting of the tongue and/ or lips, difficulty moving the lips and smiling, pain and infection. Initial_____

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(Continued)

I am not currently taking immune suppressing medications. Initial _____

I understand if I develop increased swelling, itching or spreading redness, I will immediately call Dr. Roberts.

I understand that Restylane / Restylane Fine Line / Perlane are FDA approved temporary fillers that will require periodic "touch-up" to maintain maximum correction.

I agree that during the first 24 – 48 hours following injection or until all redness and swelling are gone, I will avoid:

- 1) Extensive sun or heat exposure, including tanning salons
- 2) Alcoholic beverages
- 3) Extreme cold weather
- 4) Strenuous exercise

I understand that exposure to 1) – 4) may cause temporary but prolonged swelling, redness and/or pain at injection sites.

Initial _____

I understand the safety of Restylane injections during pregnancy is unknown. I am not aware that I am currently pregnant.

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 have read the "Restylane / Restylane Fine Line / Perlane Consent for Treatment" in its entirety and have discussed the risks, benefits and alternatives of these injectable fillers with Dr. Roberts or _____.

By my signature below, I acknowledge that I have read the "Consent for Restylane / Restylane Fine Line / Perlane Consent for Treatment" and understand it. I have been given the opportunity to ask questions. My questions have been answered fully to my satisfaction. I have been adequately informed of the risks and benefits of this treatment and wish to proceed.

Patient Signature _____ Date _____

Guardian Signature (if patient is a Minor) _____

Relationship to patient _____

Witness Signature _____ Date _____