Selena Lantry M.D., Inc.
Lantry Laser & Skin Care Center

Restylane®/ Perlane® Injectable Gel Consent Form

Name________________________________Date:___________________Age:________

Circle any of the following history you have or have had in the past:

History of Anaphylaxis - Multiple Severe Allergies - Facial Acne - Facial Rashes Hives - Herpes - Active Inflammatory process - Infection (at proposed sites) - Autoimmune Disease - Immunosuppressive Therapy - Any other Medical Disease

Explain: ____

Previous Hospitalizations/Operations: ____
____

Restylane® Perlane® Administration Consent

Restylane is a gel of hyaluronic acid generated by streptococcus species of bacteria, chemically cross linked with BDDE, stabilized and suspended in physiologic buffer at PH=7 and concentration of 20mg/ml. areas most frequently treated are: nasolabial folds, oral commissures, lips and Glabellar. Client may experience a slight burning sensation during injections.
The procedure takes about 20 minutes. Results last approximately six months.

Risks and Complications

It has been explained to me that there are certain inherent and potential risks and side affects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, and bruising, 2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction.

Photographs

I authorize the taking of clinical photographs. I understand my identity will be protected.

Pregnancy, Allergies

I am not aware that I am pregnant, have any significant Medical Diseases, or have any severe allergies.

I herby voluntarily consent to treatment with Restylane® injection for the condition known as: Facial Static Wrinkles. I have read the above and understand it. I accept the risks and complications of the procedure.

Patient Signature____Date____________

Restylane Perlane Patient History

Women: are you Lactating or Pregnant? Yes____ No____

Previous Restylane® Yes___ No___ Area: __________________ Date_____________
Complications: Yes___ No__ If yes,
Explain: ____

Have you had other dermal fillers: Yes__ No___
Type of Dermal Fillers: ___________________________Areas:__________________

History of Anaphylactic Shock: Yes___ No___

History of Allergies: ____
____

Current Medications: ____
____

Do you take any of the following?
(Please circle)

- Aspirin
- Anti-inflammatories
- Anticoagulants
- Steroids
- Non-Steroidal

(I.e. Advil, Aleve, Celebrex)

- Gingko Biloba
- Vitamin A
- Vitamin E

I understand the information on this form is essential to determine my medical and cosmetic needs and the provisions of treatment. I understand that if any changes occur in my Medical History/Health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature______________________________________Date_______________