Dermal Filler Consent

Dermal fillers are FDA approved for use in facial areas of the nose, lips and chin and their associated folds and wrinkles. Benefits generally last from 9-12 months based on the volume and type of product used. The use of fillers may be combined with other skin care treatments. Timing and frequency of associated facial treatments is important when using fillers. Frequency of injections vary among individuals according to need and personal preference. At times, the use of Botox is preferentially done prior to or in place of the use of fillers.

Minor bruising, redness and pain at the injection site is common. Serious allergic reaction is rare, but can occur which can include itching, rash, wheezing, asthma symptoms, dizziness or feeling faint. Seek medical help immediately if experiencing these symptoms.

The most commonly reported side effects were redness, swelling, pain, tenderness, firmness, lumps/bumps, bruising, discoloration, and itching. The majority were mild or moderate in severity. Most resolved within 2-4 weeks. Lumpiness, nodules, infection and or immune mediated response is possible within days to weeks after treatment.

Rare, but serious, adverse events associated with intravascular injection of filler in the face have been reports and include temporary or permanent vision impairment, blindness, cerebral ischemia or cerebral hemorrhage leading to stroke, skin necrosis, and damage to underlying facial structures.

I attest to the following:

1. I am not pregnant or Nursing _____ (Initial)

2. I do not have any of the following conditions: diabetes, coronary artery disease, rheumatoid arthritis, systemic lupus erythematosus, scleroderma, Sjogren's syndrome, history of facial nerve palsy. _____ (Initial)

3. I have never experienced an anaphylactic reaction. _____ (Initial)

Below is a list of all the medications and supplements I have taken over the last 4 weeks.

By signing below, you acknowledge that you have read and understand the above statement and authorize Diana Gallerani NP to perform treatment with dermal filler in the following areas which have been discussed during this visit.

Patient Signature_____ Date_____