UVA Health

0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Consent for Collagen or Facial Filler Injection

A. CONSENT FOR PROCEDURE

1. I authorize_____to perform the following procedure(s):

Collagen or Facial filler injection

(INCLUDE SPECIFIC LOCATION; INDICATE LATERALITY, RIGHT OR LEFT)

I understand that I may need other urgent procedures that were unanticipated. I consent to the performance of any additional procedures determined during my original procedure to be in my interests and where delay might cause additional harm.

I understand that other qualified practitioners, including residents (doctors who have finished medical school and are getting more training), may be chosen to do or help with procedures. All qualified practitioners will only perform tasks that are within their scopes of practice and for which they have been granted clinical privileges. Residents will only perform all or parts of the procedures under the supervision of my doctor.

I understand my diagnosis/condition to be: **facial rhytides**

2. I have been told about what results to expect, which includes information about the chances for the expected results and about problems that might occur during recuperation. I know that results cannot be guaranteed.

3. I have been told about and understand the risks and benefits of the procedure(s) listed above. I understand that there are risks for all kinds of surgery. Risks which can be serious, include bleeding, infection, and damage to nearby tissues, vessels, nerves, or organs. They may result in paralysis, cardiac arrest, brain damage, and/or death from both known and unknown causes. other risks for this procedure may include:
Asymmetry, incomplete correction, recurrence, need for more procedures, anaphylaxis/reaction to injection.

4. I understand the alternatives to the proposed procedure and the related risks to be: ***no treatment.***

5. I understand that for some kinds of medical equipment used during procedures, a representative from the equipment manufacturer may be present, providing consultation or performing checks on the equipment.

6. I understand that photographs and/or video or electronic recordings may occur during my procedure and may be used for internal performance improvement or educational purposes.

7. I understand that any tissues or parts removed during my procedure may be disposed of by the hospital or used for any lawful purpose including education and research.

(CONTINUED ON NEXT PAGE)

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B. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	PRINTED NAME	**DATE**	**TIME**

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO THE PATIENT:

☐ 1. Agent Named in Advance Directive ☐ 4. Adult Child ☐ 7. Other Blood Relative

☐ 2. Guardian ☐ 5. Parent ☐ 8. **Other****

☐ 3. Husband/Wife ☐ 6. Adult Brother/Sister

FOR MINOR PATIENTS:

☐ 1. Parents ☐ 2. Guardian or Legal Custodian ☐ 3. Authorized person for child in out-of-home placement

Requires review and appointment by Ethics Consult Service. See Medical Center Policy 0024, Informed Consent.

D. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT	PRINTED NAME	PIC #	**DATE**	**TIME**

SIGNATURE OF WITNESS (OPTIONAL) **REQUIRED FOR TELEPHONE CONSENTS**	PRINTED NAME	**DATE**	**TIME**

E. INTERPRETER ATTESTATION:

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID #	PRINTED NAME	**DATE**	**TIME**