Anti-wrinkle consent form template (UK)

Patient details

Full name: _____

Date of birth: _____

Phone: _____

Email: _____

Address: _____

Treatment details

Product name and formulation: _____

Areas to be treated: _____

Date of treatment: _____

About this treatment

Botulinum toxin type A is a prescription-only medicine injected in small doses to relax targeted facial muscles, softening dynamic lines. The effect typically develops over 3 to 14 days and lasts around 3 to 4 months, after which movement returns gradually. Results vary between individuals and no specific outcome can be guaranteed.

Exclusions and screening

Please confirm each of the following:

☐ I am not pregnant and not trying to become pregnant

- ☐ I am not breastfeeding
- ☐ I do not have a neuromuscular condition (for example myasthenia gravis, Eaton-Lambert syndrome, motor neurone disease)
- ☐ I am not allergic to the prescribed product or any of its constituents (including human albumin)
- ☐ I do not have an active skin infection at the treatment site
- ☐ I have disclosed all medication I take, including blood-thinning medicines and supplements

Risk acknowledgement

I understand and accept the following recognised risks of anti-wrinkle treatment:

- ☐ Bruising, redness and swelling at the injection sites
- ☐ Headache in the days after treatment
- ☐ Asymmetry of result, which may require review or adjustment
- ☐ Eyelid or brow ptosis (drooping), which is usually temporary but may last weeks
- ☐ Under- or over-correction, including a heavy or frozen feeling
- ☐ Rarely, spread of toxin effect beyond the treated area, causing muscle weakness, swallowing or breathing difficulties; I will seek medical attention urgently if these occur
- ☐ Allergic reaction, which is rare

Pre- and post-treatment notes

- ☐ I understand that alcohol, aspirin, ibuprofen and other blood-thinning medicines or supplements taken in the days before treatment increase the risk of bruising. I have not stopped any prescribed medication without medical advice.
- ☐ I have received and understood the aftercare instructions, including remaining upright for 4 hours, not rubbing the treated area, and avoiding strenuous exercise and alcohol for 24 hours.

Photography

- ☐ I consent to clinical photographs being taken before and after treatment for my confidential patient record.
- ☐ I additionally consent to my photographs being used for marketing purposes (optional).

Outcome, review and top-up policy

- ☐ I understand that results cannot be guaranteed and that individual response varies.

☐ I understand the clinic's review policy: a review appointment is offered at 2 to 3 weeks, and any adjustment or top-up is at the prescriber's discretion within that window. Requests outside the review window may be charged as a new treatment.

Patient declaration

I confirm that I have read and understood the information above, that I have had the opportunity to ask questions and that they have been answered to my satisfaction. I confirm that the information I have given is true and complete, and I consent to the anti-wrinkle treatment described.

Patient signature: _____

Print name: _____

Date: _____

Practitioner declaration

I confirm that I have explained this procedure to the patient, including its intended benefits and material risks, and any available alternative treatments, and that the patient has had the opportunity to ask questions.

Practitioner signature: _____

Print name and qualification: _____

Date: _____