Hyaluronidase consent form template (UK)

Patient details

Full name: _____

Date of birth: _____

Phone: _____

Email: _____

Address: _____

Treatment details

Reason for dissolving (e.g. migration, overfilling, lumps, unwanted result):
_____

Areas to be treated: _____

Original filler product and date, if known: _____

Filler placed at this clinic / elsewhere / unknown (circle): _____

Date of treatment: _____

Prescriber name and registration number: _____

About this treatment

Hyaluronidase is an enzyme used to break down and disperse hyaluronic acid dermal filler. It is a prescription-only medicine, prescribed for you following assessment. Change is often visible within hours and the full effect is judged over the following days. Hyaluronidase works on hyaluronic acid fillers only; it has no effect on other filler types, and product of unknown origin may not respond. More than one session may be required.

Patch test (elective dissolving)

- ☐ I have received a test dose of hyaluronidase and have been observed for a reaction in line with this clinic's protocol, and I understand that a clear patch test reduces but does not eliminate the risk of allergic reaction.

Patch test site and date: _____

Result: _____

Exclusions and screening

- ☐ I am not pregnant and not breastfeeding
- ☐ I do not have an active skin infection or inflammation at the treatment site
- ☐ I have no known allergy to hyaluronidase
- ☐ I have disclosed any allergy to bee or wasp venom
- ☐ I have disclosed all medication I take and my relevant medical history

Risk acknowledgement

I understand and accept the following recognised risks of hyaluronidase treatment:

- ☐ Allergic reaction, including rash, itching, swelling and, rarely, anaphylaxis (a severe, potentially life-threatening reaction requiring emergency treatment)
- ☐ Dissolving of my body's own natural hyaluronic acid in the treated area, which can cause temporary deflation, looseness or accentuated lines while natural hyaluronic acid replenishes
- ☐ Bruising, redness, swelling and tenderness at the injection sites
- ☐ Infection at the injection site
- ☐ Incomplete dissolving, which may require one or more repeat sessions

- ☐ An unpredictable final appearance, since the amount, age and type of existing filler cannot always be known, particularly where it was placed elsewhere
- ☐ I understand that if I wish to have new filler after dissolving, a settling period will be recommended before re-treatment

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).

Patient declaration

I confirm that I have read and understood the information above, including the risk of allergic reaction, that I have had the opportunity to ask questions and that they have been answered to my satisfaction. The information I have given is true and complete. I consent to hyaluronidase treatment as 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 (including allergic reaction and the possibility of incomplete or over-dissolving), and any available alternatives including not treating, and that the patient has had the opportunity to ask questions. A prescriber has assessed the patient and prescribed this treatment.

Practitioner signature: _____

Print name and qualification: _____

Date: _____