

Dermal Filler Consent Form

Patient Full Name: _____ Date of Birth: _____

Contact Number: _____ Email Address: _____

Absolute Contraindications — Do NOT Proceed If Any Apply

- Known allergy or hypersensitivity to hyaluronic acid or lidocaine
- Active skin infection, inflammation, or rash at or near the injection site
- Currently pregnant or breastfeeding
- History of anaphylaxis to dermal filler components
- Autoimmune connective tissue disease (e.g. lupus, scleroderma)

Relative Contraindications — Proceed With Caution

- History of cold sores or facial herpes simplex (HSV-1)
- Bleeding or clotting disorder
- Previous adverse reaction to dermal filler or injectable treatments
- History of keloid or hypertrophic scarring
- Currently taking blood-thinning medications (warfarin, aspirin, NSAIDs)
- Immunosuppressive therapy or immunodeficiency
- Recent dental procedures within the past 2 weeks

Medical History

- Current medications and supplements (including over-the-counter)
- Previous cosmetic treatments and any adverse reactions
- Bleeding disorders or anticoagulant therapy
- History of cold sores or facial herpes simplex
- Known allergies (especially to lidocaine or hyaluronic acid)
- Autoimmune conditions or connective tissue disorders
- Pregnancy or breastfeeding status
- Recent dental work or facial surgery within the past 4 weeks

Risk Disclosures

- Bruising, swelling, and redness at injection sites
- Infection at the injection site
- Nodule or granuloma formation
- Vascular occlusion — tissue necrosis risk
- Asymmetry or overcorrection
- Allergic reaction to filler components
- Filler migration from injection site
- Vascular occlusion — vision loss risk

Consent Declaration

- I confirm that I have read and understood the information provided about the dermal filler procedure, including its purpose, expected outcomes, and limitations.
- I confirm that my medical history provided is accurate and complete. I understand that withholding any medical information may be detrimental to my health and safety during the procedure.
- I understand and accept the potential risks and complications of dermal filler treatment, including but not limited to vascular occlusion, infection, asymmetry, and granuloma formation.
- I have been informed that results are not guaranteed and may vary between individuals. The longevity of results depends on factors including filler type, treatment area, and individual metabolism.
- I consent to before and after photographs being taken for my clinical record.
- I have been offered a cooling-off period to consider this treatment and am proceeding voluntarily.

Aftercare Instructions

- Avoid touching, pressing, or massaging the treated area for 24 hours
- Avoid strenuous exercise, saunas, and hot baths for 24-48 hours
- Apply a cold compress gently if swelling occurs
- Attend any scheduled follow-up appointments
- Do not apply make-up to the treated area for at least 12 hours
- Do not consume excessive alcohol for 24 hours post-treatment
- Report any unusual symptoms (severe pain, skin colour changes, visual disturbance) to the clinic immediately

Authorisation

Patient Signature

Practitioner Signature

Date