FACIAL PROCEDURAL CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

I, _____ agree to undergo_____

I have read and fully understand the following possible complications and details of the procedure.

Complications that are possible include:	INITIAL
Redness	_____
Swelling	_____
Bruising	_____
Hematoma (blood collection)	_____
Infection or allergic reactions	_____
Scarring	_____
Adjacent structure injury (nerve, muscle, blood vessels, teeth glands etc)	_____
Eye irritation (dry, watery, damage)	_____
Visual loss	_____
Asymmetry (left side not equal to right)	_____
Muscle weakness (eyelid, mouth, brow etc) or paralysis	_____
Bleeding	_____
Pain (late or immediate onset)	_____
Ectropion or entropion (out or inward eyelashes)	_____
Clots in legs, lungs or death	_____
Failure and need for repeat procedure (incl. extra cost)	_____
Unexpected complications unrelated to procedure (falls etc)	_____
Pigmentation increase or permanent loss	_____
Lumpiness, divets, new wrinkles	_____
Exacerbation of psychiatric and or psychological conditions	_____
Risk of interruption to work, travel and social schedules	_____
Skin death (necrosis)	_____

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Implant failure or dysfunction (if implants used) _____

Granulomas (allergic lumps) _____

Septicaemia (blood poisoning) _____

Systemic collapse/aggravation of illness _____

Anaesthetic or sedation reactions _____

I understand all the above complications and have been given adequate opportunity to have my questions answered _____

I agree to follow all preoperative and postoperative instructions including cessation of smoking _____

I understand upon discharge my carer takes responsibility for my general care and will supervise me closely including excluding me from driving (and similar activities) and important decisions for the first 24 hours _____

I agree to report any physical or psychological concerns immediately and allow Dr Murray to manage any of those that relate to my procedure _____

I release Dr Murray's or representatives from medico legal liability _____

I have been offered a copy of this document _____

I agree to contact the practice manager with any complaints and to not use social media or the internet as a complaint platform. _____

NAME: (Print) _____

SIGNATURE: _____ DATE: _____

WITNESS NAME: (Print) _____

WITNESS SIGNATURE: _____ DATE: _____

I cannot dispute what I have read, agreed to and signed above . If I do then I agree to pay all costs incurred by ACM if I breach this agreement.

I agree to follow the ACM social media policy and pay all costs incurred by ACM if I breach this policy.

I understand that photographs are for clinical use only. I am responsible for taking my own photographs for my records. (please initial) _____

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