Kimberly Cockerham, MD, FACS
Oculofacial Plastic Surgery
Eyelid & Orbital Oncology
Thyroid Eye Disease
Neuro-Ophthalmology

Consent for Use of Botox

I,_____, hereby authorize Dr. Kimberly Cockerham / _____ and such assistants as may be selected to perform the following procedure of BOTOX / XEOMIN INJECTION(S), for treatment of:

_____

INDICATIONS AND ALTERNATIVES

Botox is a brand name for botulinum toxin type A, a neurotoxin that blocks messages between muscles and the nerves that control them. The effects of Botox become apparent 2-5 days after injection and generally last for 3-4 months. The FDA has approved the use of Botox to treat facial dystonia (spasms), strabismus (crossed eyes), and to temporarily soften facial rhytids (wrinkles). While the FDA has not approved injections to improve the appearance of wrinkles in other areas of the face, physicians may perform these "off-label" procedures. There are alternatives to Botox, including no treatment, or medicines or surgery on my facial nerves and muscles.

SIDE EFFECTS AND COMPLICATIONS

Include but are not limited to:

- Post treatment discomfort, swelling, redness, and bruising
- Facial asymmetry (one side looks different than the other)
- Generalized weakness
- Permanent loss of muscle tone with repeated injection
- Nausea or headache
- Paralysis of a nearby muscle leading to: droopy eyelid, double vision, inability to close eye

CONTRAINDICATIONS

You should not have Botox if:

You are pregnant; nursing; allergic to albumin; have an infection, skin condition, or muscle weakness at the site of the injection.

I understand the above, and have had the risks, benefits, and alternatives explained to me. No guarantees about results have been made. I give my informed consent for Botox injections today as well as future treatments as needed.

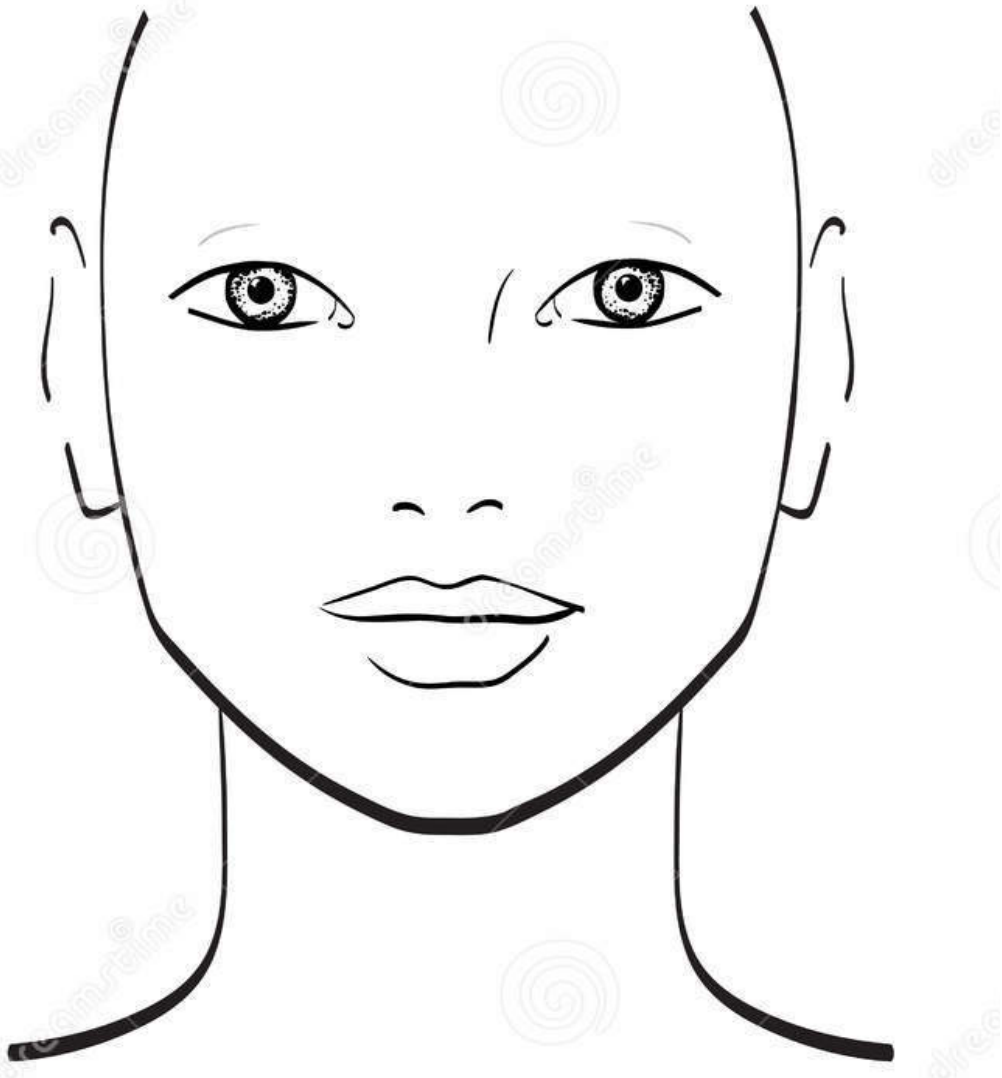
Patient Signature (or Person Authorized to Sign for Patient) Date

Kimberly Cockerham, MD, FACS
Oculofacial Plastic Surgery
Eyelid & Orbital Oncology
Thyroid Eye Disease
Neuro-Ophthalmology

NAME: _____ **D.O.B:** _____

DIAGNOSIS: _____ **D.O.S.** _____

BOTOX INJECTION FACE MAP



PHYSICIAN SIGNATURE: _____

LOT# _____

EXP. DATE: _____

UNITS: _____