LVPEI
So that all may see

L V Prasad Eye Institute
Kallam Anji Reddy Campus
L V Prasad Marg, Banjara Hills, Hyderabad - 500034, India

Informed Consent for Botulinum toxin/Filler injection

(The consent of this form have been explained to me in my spoken language)

I, Mr./ Ms/ on behalf of minor child _____ MR No_____

hereby give my consent and authorize Dr _____

(The list of possible assistant(s), all of who are credentialed to provide surgical services at the hospital, has been intimated to me)

To treat the following condition(s):

☐ HEMIFACIAL SPASM ☐ BENIGN ESSENTIAL BLEPHAROSPASM

☐ ORBICULARIS MYOKIMIA ☐ APRAXIA OF LID OPENING ☐ COSMETIC

By performing the following procedure(s):

BOTULINUM TOXIN INJECTION UNITS UNDER TOPICAL ANAESTHESIA

1. The care provider has explained my eye condition to me, the benefits of having the above treatment procedure, and alternate ways of treating my condition. I understand that no guarantees have been made to me about the result of the treatment. The alternatives to this procedure include:

☐ NO TREATMENT ☐ ORAL MEDICATIONS ☐ NEUROSURGERY (HFS)

2. The care provider has discussed with me the reasonably foreseeable risks of the treatment, and that there may be undesirable results. Apart from the rare complications like hemorrhage and infection, which can happen with any surgical procedure, the specific risks that are related to this procedure include:

☐ PTOSIS (DROOPY EYELID) ☐ LAGOPHTHALMOS (INCOMPLETE EYE CLOSURE)

☐ LIMITED PERIOD OF ACTION ☐ REFRACTORY (NO ACTION)

3. I understand that during the treatment, a condition may be discovered which was not know about before the treatment started. Therefore, I authorize the care provider to perform any additional or different treatment which is thought necessary and available.

4. I consent to the administration of local, regional or general anesthesia and/ or sedation as deemed most appropriate for the procedure to be performed. (The list of possible anesthesia providers, all of who are credentialed to provide anesthesia at this hospital, is available).

5. Any tissue, parts, or substances removed during the procedure may be retained or disposed of in accordance with customary scientific, educational and clinical practice.

AUTHORIZATION OF THE PATIENT/ GUARDIAN

I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with my doctor or his/ her designee, and hereby consent to the components of my patient care that are mentioned above in this consent.

Signature or thumb impression
of the patient _____ Date _____

Signature or thumb impression
of the guardian _____ Date _____

Name _____ Relationship _____

Signature or thumb impression
of the witness _____ Date _____

Name _____ Relationship _____

Doctor's signature _____ Date _____