Alexis Alexandridis MD Inc.

INFORMED CONSENT FOR AXILLARY BOTULINUM TOXIN TREATMENT

PATIENT NAME: _____

DATE OF BIRTH: _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask Dr Alexandridis prior to signing the consent form.

THE TREATMENT

Botulinum toxin (Botox® and similar agents) is a neurotoxin produced by the bacterium *Clostridium botulina*. Botulinum toxin can relax the muscles on areas of the face and neck and can also affect the apocrine glands of the axilla. Treatment with botulinum toxin can cause decreased perspiration or sweating in the underarm area. Botox® is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes 15-30 minutes and the results can last up to 9 months. With repeated treatments, the results may tend to last longer. The injections are customized for every patient, depending on their needs.

Initial ____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure. No procedure is completely risk-free. The following adverse events may occur, but there may be unforeseen risks and/or risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment.

In this specific instance, such risks include, but are not limited to, 1. Post treatment discomfort, swelling, redness, and bruising, and 2. Flu-like symptoms may occur. In addition, it is possible to experience an incomplete block where more injections are required to achieve the goal.

Initial ____

ALLERGIES, NEUROLOGIC DISEASE, & PREGNANCY

I do not have any significant neurologic disease including but not limited to Myasthenia Gravis, Multiple Sclerosis, Lambert-Eaton syndrome, amyotrophic lateral sclerosis (ALS), or Parkinson's Disease.

I do not have any allergies to the toxin ingredients, or to human albumin.

If I am a female, I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing).

Initial ____

Alexis Alexandridis MD Inc.

INFORMED CONSENT FOR AXILLARY BOTULINUM TOXIN TREATMENT

ALTERNATIVE PROCEDURES

Alternatives to the procedures (including topical agents or not treating at all) and options that I have volunteered for have been fully explained to me.

Initial ____

POST-PROCEDURE INSTRUCTIONS

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2 – 10 days and usually lasts up to 9 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all.

I understand that in order to prevent significant complications related to migration of the neurotoxin, I must not manipulate or rub the areas of the injections for 4 hours.

Initial ____

The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor who treated me immediately. I also state that I read and write in English.

_____

Patient Name (Print) Patient Signature Date

I am the treating physician. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Alexis Alexandridis MD FACS *Doctor's Signature* *Date*