DFW Medical Spa
1009 Glade Road, Ste. E
Colleyville, TX
469-279-9897

Neurotoxin Treatment Post Care Information & Instructions

1. Results are typically seen in 2-6 days, optimal results are seen in 14 days.
2. Maintain in an upright posture and avoid exercise for 6 hours.
3. Do not take Vitamin A, Aspirin or consume alcohol.
4. NO hats, headbands or visors after treatment (for 10 days post treatment)
5. Avoid sex immediately following injections, it raises the blood pressure.
6. Wipe the treated areas with alcohol before and after your make up application to protect from bacteria the day of treatment.
7. You may apply ice, arnica or any other anti-inflammatory topical agents to treat or prevent pain/bruising/swelling.
8. Results typically last anywhere from 2-4 months. (this is dependent on lifestyle, and dosage and can be different for each client)
9. Wash face and forehead in an upward direction, wash “crows feet” in an outward direction.
10. After the 14 days, if you continue to have more movement than desired, you may need to follow up to add more toxin to that area. Please wait the full 2 weeks before scheduling a follow up visit.

If you have the following scheduled in the next 24 hours up to 10 days, please consider rescheduling your appointment with us. It is important for you to receive the best results possible and the following can alter your results.
*No scalp, neck or massages for 10 days.
*If you plan to get your hair treated (would require washing) in the next 72 hours, please count on doing your neurotoxin treatment following your hair appointment.
*No facial treatments for at least 72 hours.

Possible Side Effects and Less Common Complications -

Side effects associated with the injection include: localized pain, infection, inflammation, tenderness, swelling redness, and/or bleeding/bruising.

Less common reactions may include: nausea, fatigue, flu-like symptoms, headache, excessive weakness of the muscle, temporary eyelid drooping, and temporary brown drooping.

Please Call our office at 817-715-1852, If you are experiencing any of the following: shortness of breath, difficulty swallowing, difficulty talking, severe lower eyelid droop, obstructed vision, excessive weakness around the injection site, rash or a sign of an allergic reaction.

**Do not have neurotoxin injections if you are allergic to any of the ingredients in the botulinum toxin or had a reaction to any other botulinum toxin product; have severe allergies and with a history of anaphylaxis; are pregnant or nursing; are under the age of 18; have an active infection at the site of injection or are on immunosuppressive therapy.

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Neurotoxin Injection COSMETIC Consent Form(Botox, Xeomin, Dysport)

To the patient: You have the right to be informed about your treatment so that you may make a decision to undergo the procedure, knowing the risks and hazards involved. I _____ (first and last name) **consent** to having **neurotoxin injection** treatment carried out upon myself for the improvement of ___fine lines/wrinkles.

I understand that I am required to have photographs taken before, during and after treatment for my medical records.

Neurotoxin injection is injected with a small needle into the muscle, with the aim of inhibiting the underlying muscle contraction, therefore improving facial lines and appearance.

I have been informed about the treatment, procedure, indications, expected results and possible side effects. I understand that I may experience swelling, redness, tenderness, slight headache, pain and / or bruising that may occur for several days after my treatment, however these symptoms will resolve. Rarely an adjacent muscle may be weakened for several weeks after injection. I have been advised of the risks involved and the expected benefits of **Neurotoxin injection** treatment.

Although the results are usually dramatic I have been informed that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning the expected results in my case.

I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantee can be made as to the exact results of this procedure. I understand that whilst every precaution will be taken to prevent complications and that whilst complications from this procedure are rare, they can and sometimes do occur.

I accept responsibility for any complications that may occur and thereby absolve DFW Medical Spa and any associated person of any blame resulting there from.

I agree that this constitute full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

I understand that the terms of payment require full settlement on or before the day of my treatment.

Patient Signature _____ Date _____

Email _____ Date _____

Phone _____