



Patient Education Literature

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues. "An educated patient is the best patient."

Facial Fillers (Juvederm, Restylane, RHA)

Definition:

A facial filler is a substance injected into the skin or tissue beneath the skin to correct volume loss and to decrease the appearance of facial wrinkles, folds, or hollows.

Purpose of Procedure:

The procedure is performed to temporarily volumize the face and to decrease the appearance of unwanted lines and wrinkles.

Preparation:

Ideally, this procedure will not be performed if you are currently taking, or have recently taken any medication that may interfere with your ability to clot your blood (blood thinners, aspirin, anti-inflammatory medicines, etc...). The most common of these medications are aspirin and all related pain relievers or anti-inflammatory compounds (whether prescription or over-the-counter). We will have reviewed all of your current medications with you during the pre-operative/pre-procedure consultation. You are obligated to inform us if anything has changed (medication or otherwise) since your previous visit.

Procedure:

This procedure involves the injection of the filler into the skin and tissues beneath the skin. This may cause temporary pain and discomfort to the area. Topical numbing creams and/or ice may be used to decrease the pain of injection. Bruising may occur, but will usually resolve within 2-3 days. Rarely, bruising may persist for 2-3 weeks. Being on blood thinners may increase the risk of bleeding. You should notice improvement immediately, but the full effect may take a few weeks for the filler to integrate into the tissue and for the surrounding swelling to decrease. The effects of the injection normally last for 6-18 months.

Post Procedure:

Following filler injection, you should not lay flat, have a facial, or perform strenuous exercise for 24 hours. Make-up may be applied after 24 hours. Mild pressure and ice to the affected areas may decrease the risk of bruising.

Off Label Use:

Some injection sites may not be FDA-approved.

Possible Complications of the Procedure:

This is a safe procedure, however, there may be uncommon risks associated with it. While we have discussed these and possibly others in your consultation, we would like you to have a list so that you may ask questions if you are still concerned. It is important that every patient be made aware of possible outcomes that may include, but are not limited to:

- Bruising
- Bleeding
- Discomfort at the injection site
- Headache
- Allergic reaction to the injected material
- Blue discoloration to the skin overlying the injection site
- Palpability of the product in the skin and subcutaneous tissues
- Necrosis of the facial skin
- Blindness/stroke
- Swelling
- Infection
- Cosmetic change
- Swelling of the filler after COVID vaccination

We provide this literature for patients and family members. It is intended to be an educational supplement that highlights some of the important points of what we have previously discussed in the office. Alternative treatments, the purpose of the procedure / surgery and the points in this handout have been covered in our face-to-face consultation(s).

Preprocedural Checklist (Please Complete):

- Is there a chance you may be pregnant? YES/NO
- Are you breastfeeding? YES/NO
- Are you currently taking antibiotics for an infection? YES/NO
- Are you currently suffering from an infection? YES/NO
- Are you currently taking and medications that may increase bleeding? YES/NO: _____
- Do you have a history of cold sores? YES/NO
- Are you planning any travel in the next 2 weeks? YES/NO
- Are you at least 21 years of age? YES/NO

I/We have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedure to be used, and I/we have sufficient information to give this informed consent.

I/We certify this form has been fully explained to me/us, and I/we understand its contents.

I/We understand every effort will be made to provide a positive outcome, but there are no guarantees.

Physician/Nurse Practitioner Date

Witness Date

Patient/Guardian Date