

## CHARLOTTESVILLE DERMATOLOGY PLC

Anna M. Magee, MD    Deborah M. Elder, MD    Chelsi Miller, NP

600 Peter Jefferson Pkwy, Suite 230  
Charlottesville, VA 22911

Tel: 434-984-2400  
Fax: 434-984-1147

### RESTYLANE® AND PERLANE PATIENT INFORMATION AND INFORMED CONSENT

As a patient of Charlottesville Dermatology PLC you have requested administration of Restylane® or Perlane, a stabilized hyaluronic acid used in the correction of moderate to severe facial wrinkles and folds. All medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to make you aware of the nature of the procedure and its risks in advance so that you can decide whether or not to go forward with the procedure.

**PROCEDURE:** Restylane® or Perlane is administered via a syringe, or injection, into the areas of the face sought to be filled with the hyaluronic acid to eliminate or reduce the wrinkles and folds. An anesthesia, numbing medicine used to reduce the discomfort of the injection(s) may or may not be used. The treatment site is washed first with an antiseptic (cleansing) solution. Restylane® and Perlane are clear, transparent gels that are injected under your skin into the tissue of your face using a thin, 30-gauge needle. The depth of the injection(s) will depend on the depth of the wrinkle(s) and the location. Multiple injections might be made depending on the site, depth and technique used. Following each injection the area will be gently massaged to conform to the contour of the surrounding tissues. If the treated area is swollen directly after the injection, ice may be applied on the site for a short period.

After the first treatment, additional treatments may be necessary to achieve the desired level of correction. Periodic touchup injections help sustain the desired level of correction.

**RISKS/DISCOMFORT:** Although a very thin needle is used, common injection-related reactions could occur. These could include some initial swelling, pain, itching, discoloration, bruising or tenderness at the injection site(s). You could experience increased bruising or bleeding at the injection site(s) if you are using substances that reduce blood clotting such as aspirin or other nonsteroidal antiinflammatory drugs such as Advil. These reactions generally lessen or disappear within a few days but may last for a week or longer. After treatment you should minimize exposure of your face to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away.

As with all injections, this procedure carries the risk of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken.

Some visible lumps may occur temporarily following the injection. Some patients may experience additional swelling or tenderness at the injection site(s) and in rare occasions pustules might form. These reactions might last for as long as approximately two weeks, and in some cases may need to be treated with oral corticosteroids or other therapy.

Restylane® and Perlane should not be used in patients who have experienced this hypersensitivity, those with severe allergies, and should not be used in areas with active inflammation or infection (e.g., cysts, pimples, rashes or hives). Restylane® and Perlane should not be used in areas other than the tissues of the face.

If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after treatment with Restylane® or Perlane, or if you have recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the injection site(s).

Most patients are pleased with the results of Restylane® or Perlane use. However, like any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely or that you will not require additional treatments to achieve the results you seek. While the effects can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within six months to a year involving additional injections for the effect to continue.

**BENEFITS, ALTERNATIVES AND COST:** Restylane® and Perlane have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect, once the optimal location and pattern of cosmetic use is established, can last six months or longer without the need for additional treatments. This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. The cost of treatment will be billed to you individually. Since most uses of Restylane® and Perlane are considered cosmetic procedures by insurance companies, they are generally not reimbursable by government or private health care insurers.

Other alternative treatments, which vary in sensitivity, effect and duration, include animal-derived collagen filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants, or bacterial toxins that can paralyze muscles that cause some wrinkles.

**CONSENT:** Your consent and authorization for this procedure again is strictly voluntary. By signing this informed consent form, you hereby grant authority to Charlottesville Dermatology PLC to perform facial augmentation and filler therapy/injections using Restylane® or Perlane, and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to my satisfaction and all of my questions have been answered. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure.

I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment.

I agree to notify Charlottesville Dermatology PLC of any complication that might arise following treatment.

Patient Name (print): \_\_\_\_\_ Chart #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or Parent/Legal Guardian)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
(Charlottesville Dermatology PLC Representative)