



ABSOLUTE
COSMETIC MEDICINE

PROCEDURAL CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

I, _____ agree to undergo _____

I have read and fully understand the following possible complications and details of the procedure.

Complications that are possible include:

INITIAL

Redness.

Swelling.

Bruising.

Hematoma (blood collection).

Infection or allergic reactions.

Scarring.

Adjacent structure injury (nerve, muscle, blood vessels, teeth glands etc).

Eye irritation (dry, watery, damage).

Visual loss.

Asymmetry (left side not equal to right).

Muscle weakness (eyelid, mouth, brow etc) or paralysis.

Bleeding.

Pain (late or immediate onset).

Ectropion or entropion (out or inward eyelashes).

Clots in legs, lungs or death.

Failure and need for repeat procedure (incl. extra cost).

Unexpected complications unrelated to procedure (falls etc).

Pigmentation increase or permanent loss.

Lumpiness, divets, new wrinkles.

Exacerbation of psychiatric and or psychological conditions.

Risk of interruption to work, travel and social schedules.

Skin death (necrosis).

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- Implant failure or dysfunction (if implants used). _____
- Granulomas (allergic lumps). _____
- Septicaemia (blood poisoning). _____
- Systemic collapse/aggravation of illness. _____
- Anaesthetic or sedation reactions. _____
- I understand all the above complications and have been given adequate opportunity to have my questions answered. _____
- I agree to follow all preoperative instructions including cessation of smoking. _____
- I understand upon discharge my carer takes responsibility for my general care and will supervise me closely including excluding me from driving (and similar activities) and important decisions for the first 24 hours. _____
- I agree to report any physical or psychological concerns immediately and allow Dr Murray to manage any of those that relate to my procedure. _____
- I release Dr Murray and all of his staff or representatives from medico legal liability. _____
- I have been offered a copy of this document. _____

NAME: (Print) _____

SIGNATURE: _____ DATE: _____

WITNESS NAME: (Print) _____

WITNESS SIGNATURE: _____ DATE: _____

I cannot dispute what I have read, agreed to and signed above. If I do then I agree to pay all costs incurred by Absolute Cosmetic Medicine if I breach this agreement.

I agree to follow the Absolute Cosmetic Medicine social media policy and pay all costs incurred by Absolute Cosmetic Medicine if I breach this policy.

I understand that photographs are for clinical use only.

I am responsible for taking my own photographs for my records (*please initial*). _____

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