FACIAL 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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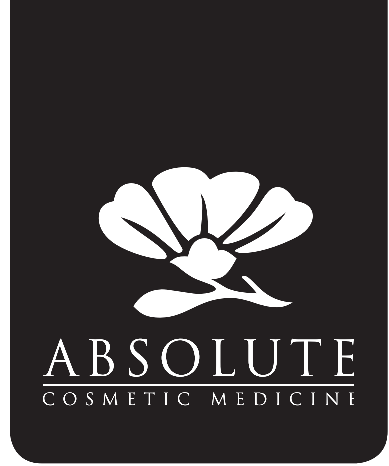
Image 21, Suite 2, 21 Stirling Highway, Nedlands, WA 6009



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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 and postoperative 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's or representatives from medico legal liability ______

I have been offered a copy of this document ______

I agree to contact the practice manager with any complaints and to not use social media or the internet as a complaint platform. ______

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 ACM if I breach this agreement.

I agree to follow the ACM social media policy and pay all costs incurred by ACM 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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