Business name _____

Injectable Treatment Consent

This is a medical treatment with real risks, covered in more detail further down: please answer honestly, even if a question feels repetitive or unlikely to apply to you. You're welcome to ask the practitioner anything before you go ahead.

Full name

Date of birth

Home address

This treatment cannot legally be provided to anyone under 18 in England, even with a parent's permission.

Are you under 18? ☐ Yes ☐ No

Emergency contact (name and relationship)

GP name (so we can follow up if needed)

Do you smoke? ☐ Yes ☐ No

Do you regularly drink alcohol? ☐ Yes ☐ No

Are you pregnant, breastfeeding, or trying to conceive? ☐ Yes ☐ No

Any known allergy to local anaesthetic, lidocaine, or hyaluronic acid? ☐ Yes ☐ No

Do you have a bleeding or clotting disorder, or an autoimmune condition? ☐ Yes ☐ No

Are you taking blood thinners, aspirin, or anti-inflammatory medication regularly? ☐ Yes ☐ No

Do you have an active cold sore, skin infection, or breakout in the treatment area today? ☐ Yes ☐ No

Have you had Botox or filler anywhere on your face in the last 2 weeks? ☐ Yes ☐ No

Please list current medications and any relevant medical history

Risks: bruising, swelling, tenderness and temporary asymmetry are common and usually settle within days. Rare but serious complications (including vascular occlusion) are possible — contact us straight away if you notice severe pain, unusual blanching of the skin, or vision changes after treatment.

- [ ] I've had the chance to ask questions and I understand the risks explained above.
- [ ] I agree to before/after photos being taken for my clinical record (not for marketing unless I separately agree).
- [ ] I confirm the information above is accurate, understand incomplete answers increase my risk, and consent to this treatment and any emergency care my practitioner judges necessary.

- [ ] I give my explicit consent for the business named above to use the health information on this form to provide my treatment safely.

Client's signature _____ Date _____

Client's name in capitals _____

Therapist's signature _____ Date _____