Consent and consultation form

For patients treated with NUCEIVA® ▼ (botulinum toxin type A)

Nuceiva® ▼ (botulinum toxin type A) is indicated for the temporary improvement in the appearance of moderate to severe vertical lines between the eyebrows seen at maximum frown (glabellar lines), when the severity of the above facial lines has an important psychological impact in adults below 65 years of age[1]

Reporting side effects.

If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in the package leaflet. You can also report side effects directly via the yellowcard scheme at **https://yellowcard.mhra.gov.uk.** By reporting side effects, you can help provide more information on the safety of this medicine.

Name: _____ Home Tel: _____

Address: _____ Mobile: _____

Town: _____ Email: _____

Postcode: _____ Date of birth: _____

Medical history

Please complete the following medical questionnaire and return to your healthcare professional; this information will help your practitioner to determine the best treatment approach.

Have you had any dermal filler treatment or botulinum toxin (sometimes referred to as muscle relaxing injections)? Y ◯ N ◯

If 'Yes', which treatment did you receive, what areas were treated and when?

_____

_____

_____

Have you previously received any other aesthetic treatments (e.g. laser, peels, dermabrasion, mesotherapy etc.) Y ◯ N ◯

If 'Yes', please give details:

_____

_____

If you have had injections in the past, have you had Infection or inflammation at the injection sites? Y ◯ N ◯

Have you had in the past any complications with previous botulinum toxin injections? Y ◯ N ◯

Are you currently receiving treatment for any condition? Y ◯ N ◯

If 'Yes', please give details:

_____

_____

What medicines or supplements are you taking? (please list)

_____

_____

_____

_____

Do you smoke? Y ◯ N ◯
If 'Yes', how many cigarettes per day? _____

If 'No', have you ever smoked? Y ◯ N ◯
When did you give up? _____

Do you drink alcohol? Y ◯ N ◯
If 'Yes', how many units per week? _____

Do you take regular exercise? Y ◯ N ◯
If 'Yes', what type of exercise do you do?

_____

_____

_____

_____

Have you had any surgery? If 'Yes', please give details Y ◯ N ◯

Have you ever been admitted to hospital? If 'Yes', please give details: Y ◯ N ◯

Do you suffer from any allergies? If 'Yes', please give details: Y ◯ N ◯

REFERENCE
1. Nuceiva® SmPC

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	Y	N
Are you pregnant, breast feeding or planning to be?	◯	◯
Do you have a history of allergy/anaphylaxis?	◯	◯
Do you have a history of severe allergy/ anaphylaxis to botulinum toxin, human albumin or sodium chloride?	◯	◯
Do you suffer from generalised disorders of muscle activity (e.g. myasthenia gravis or Eaton Lambert Syndrome)?	◯	◯
Do you suffer from any other neuromuscular or muscular disorder?	◯	◯
Do you have any history of dysphagia and aspiration?	◯	◯
Do you have any pre-existing neuromuscular disorders?	◯	◯

Have you suffered or are you suffering from any of the following?

	Y	N		Y	N		Y	N
Heart disease/angina	◯	◯	Depression	◯	◯	Glaucoma/cataract	◯	◯
Thyroid problems	◯	◯	High/low blood pressure	◯	◯	Sexually transmitted infection (e.g. HIV or hepatitis B)	◯	◯
Auto-immune disease	◯	◯	Diabetes	◯	◯	Bell's/facial palsy	◯	◯
Asthma/bronchitis	◯	◯	Stomach ulcer/colitis	◯	◯	Phlebitis	◯	◯
Convulsions	◯	◯	Skin disease (e.g. acne)	◯	◯	Bleeding disorders (e.g. haemophilia)	◯	◯

If you feel unsure or have any questions about the above please discuss these with your practitioner. If the answer is yes to any of the above, your practitioner may ask for further details. Treatment may be refused or delayed if it is not considered in your own interest to proceed.

All information provided will be treated as strictly confidential.

Advised consent

Please ask your treating practitioner for a copy of the Nuceiva® package insert.

I confirm that my treating practitioner, _____, has:

- provided me with sufficient information about the treatment detailed overleaf in order to make an informed decision
- given me the opportunity to ask all remaining questions I may have about the treatment, and has answered them to the best of their ability
- given me the time to consider the treatment detailed overleaf
- received the relevant medical history information from me to the best of my knowledge

I therefore consent to receiving the described treatment by my treating practitioner.

To be completed by patient:	**Treatment 1**	**Treatment 2**
Patient signature:		
Date of treatment:		
To be completed by the treating practitioner:		
Nuceiva lot number:		
Date of administration:		
Notes:		

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk or search MHRA Yellow Card in the Google Play or Apple App store. Adverse events should also be reported to Evolus International Ltd at medicalinformation@evolus.com or 08000541302.