INTRALINE

DERMAL FILLER TREATMENT
PATIENT CONSENT FORM

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Medical History

Please complete the following medical questionnaire

	Y	N
Are you pregnant or breastfeeding?	○	○
Do you have a history of severe allergy/anaphylaxis?	○	○
Are you currently receiving any medical treatment? If so, please provide more details:	○	○

	Y	N
Have you previously received any aesthetic treatments (ex. laser, peels, dermabrasion, etc.) If so, please provide more details:	○	○

	Y	N
Have you had any treatment with dermal fillers? If so, which treatment did you receive, what areas were treated and when?	○	○

	Y	N
Did you experience any side effects related to the treatment? If so, please provide more details:	○	○

	Y	N
Have you ever suffered from auto-immune disease or disease affecting the immune system?	○	○
Do you have any cutaneous (skin) infection or inflammatory problems (ex. herpes, acne, etc.)?	○	○
Are you currently taking any steroids, aspirin, anticoagulant (ex. warfarin) or certain drugs that reduce or inhibit the hepatic metabolism?	○	○
Do you suffer from acute rheumatic fever or recurrent sore throat?	○	○
Do you suffer from any allergies, in particular to hyaluronic acid, amide type local anaesthetics or lidocaine?	○	○
Do you suffer from untreated epilepsy?	○	○
Do you tend to develop hypertrophic scarring?	○	○
Do you suffer from porphyria?	○	○
Do you suffer from cardiac conduction disorders?	○	○

If so, please provide more details:

If the answer is yes to any of the above, your medical practitioner may ask for further details. Treatment may be refused if it is not considered in your own interest to proceed.

On a voluntarily undertaken basis:

I am interested in speaking to the media about my experience with Intraline and my medical practitoner can provide more information about this.

◯ I agree ◯ I disagree

My medical practitoner may use photos taken before and after my treatment for the following purposes. I have seen these photos and agree or disagree with their use as follows.

Scientific purposes	◯ I agree	◯ I disagree
Media purposes	◯ I agree	◯ I disagree

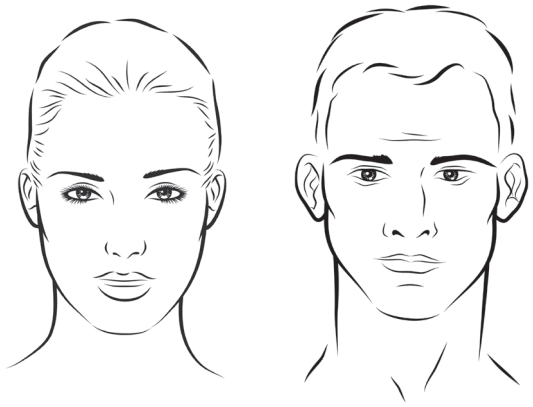
Please ask your treating practitoner for a copy of the Intraline package insert.

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.

Signed: _____ Date: _____



Lot Stickers: _____

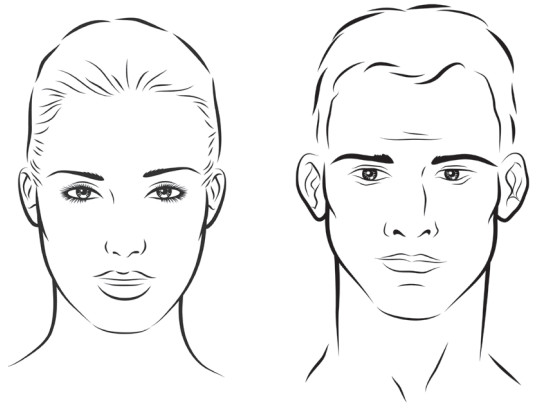
Date: _____

Volume: _____

Treated Areas: _____

Notes: _____

_____



Lot Stickers: _____

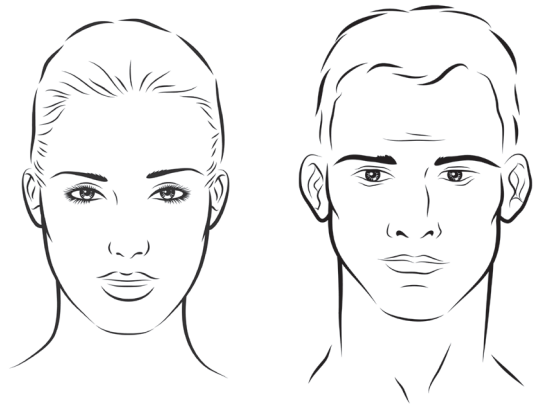
Date: _____

Volume: _____

Treated Areas: _____

Notes: _____

_____



Lot Stickers: _____

Date: _____

Volume: _____

Treated Areas: _____

Notes: _____

_____

Health Care Professional's Name: _____

Clinic Name: _____

Clinic Address: _____

_____

Telephone: _____

Email: _____

Patient Consent

Intraline's Dermal Fillers are made from sterile and transparent gel based cross-linked non-animal synthetic hyaluronic acid. Hyaluronic acid is a natural substance present in the human body. The cross-linked hyaluronic acid in Intraline mimics the natural hyaluronic acid already present in the human body.

Intraline's Dermal Fillers utilize an innovative spherification technology, which smoothes Hyaluronic Acids' traditionally angular rhomboid molecular structure, leading to smoother, more natural results, which can last 6–12 months.

However, it is important to emphasize that the effect is very individual and can vary depending on the skin type, age*, treated area and possible previous treatments in the same area. A follow-up of the treatment can contribute to prolonging the effect of the initial treatment.

Although hyaluronic acid is a natural component of the (skin) dermis, its injection may in very rare cases provoke undesired reactions such as hematoma, necrosis, pigmentation and granuloma. After a treatment with Intraline, certain reactions of short duration can occur. Common and expected reactions are skin redness, tenderness and swelling or pain in the treated area. These inconveniences may last from one hour up to a week. After treatment the patient should avoid strenuous exercise and protect the treated area from intense sunlight and extreme temperatures.

I hereby acknowledge that the practitioner performing the treatment has in a satisfactory way informed me about the characteristics and usage of Intraline. The practitioner has thoroughly described the reactions that can occur after treatment and informed me on how to care for the treated area after performed injection.

By signing this document I confirm that I have answered the questions from the practitioner regarding my medical history in an honest way. I have also informed the practitioner about possible allergies and previous treatments in the same area. My signature confirms that I agree to treatment with Intraline.

_____

Name of patient

_____ _____

Signature of patient Date

INTRALINE

www.intraline.com