Silverado
Medical & Aesthetic Clinic

Patient Info:

BOTOX Treatment Consent Form

For the treatment of migraine

BOTOX® is the trade name for a purified neuromuscular toxin fabricated and marketed by Allergan Inc. Low doses of BOTOX® (onabotulinumtoxinA) are injected into muscles in the head and neck. The toxin temporarily prevents the release of a chemical transmitter called acetylcholine, preventing motor nerve activation of muscle.
This blockade relaxes the muscle and is the basis for its use in cosmetics. More importantly, BOTOX® also moderates molecules which can amplify pain signals in sensory nerves. These nerves are thought to be overactive, or 'sensitive', in migraine.

You should not have BOTOX® if you are pregnant or lactating, have a neurological condition that causes paralysis (such as myasthenia gravis), muscle weakness or difficulty swallowing, or are taking aminoglycoside antibiotics. You should not receive BOTOX® if you have had an allergic/anaphylactic reaction to it, or have an active infection in the skin of the head or neck. You should disclose any other BOTOX® treatments you have had within the past three months, as there is a maximum safe cumulative dosage over this period (360 units).

There are few side effects associated with this treatment. There is a risk that it will have no effect. Some discomfort may be experienced as the needle is inserted. Bruising may occur at the sight if injection. The muscles responsible for elevating the eyebrows may be temporarily affected, resulting in an eyebrow droop. A minority of patients may experience a temporary increase in neck pain.

The cost of BOTOX® itself is not included in Alberta Health Services, but 80% is covered by the majority of insurance plans.

After reading and understanding the information contained above, and understanding the explanation provided by my treating clinician, I consent to receive BOTOX® treatment for my chronic pain. I will not rub the injection sites, bend over or engage in heavy exercise for 4-6 hours after the treatment.

Patient Signature_____ Date: _____

Physician Signature_____