

HYALURONIDASE INFORMED CONSENT

I am signing this document to reflect that the nature of the hyaluronidase injection has been explained to me. I understand hyaluronidase is indicated as an adjuvant to increase the absorption and dispersion of other injected medications.

The risks and possible complications of hyaluronidase injections have been discussed with me in detail and all of my questions have been answered. I realize that there is always the possibility of complications, such as, but not limited to:

- Infection
- Bleeding or bruising at the treatment site
- Some pain or discomfort at the time of injection

Additionally, please observe the following after injection with hyaluronidase:

- Immediately after the injection, the most common reported side effects are temporary redness, bruising and swelling at the treatment site, which typically resolve within 2 to 5 days. Cold compresses may be used immediately after the treatment to reduce these side effects.
- Avoid touching the treated area for six hours following treatment.

I have read and understand this consent:

Patient Name (please print) _____

Patient Signature _____ **Date** _____

Medical Injector Signature _____ **Date** _____