Practice / stamp

Medical History and Consent to Injectable Treatment

Client details

Full name

Date of birth

Phone

Date

CLIENT RECORD / CONSENT TO NON-SURGICAL COSMETIC INJECTABLE TREATMENT

Absolute contraindications to injectable treatment

- Being under 18 — this clinic does not carry out cosmetic injectable treatment on anyone under 18, in line with the guidance of the Medical Council of Malta and the Council for the Professions Complementary to Medicine on cosmetic procedures
- Pregnancy and breastfeeding
- Autoimmune conditions (Hashimoto's, rheumatoid arthritis, lupus, multiple sclerosis)
- Cancer (active or under treatment)
- Poorly controlled diabetes
- Any active infection, temperature or cold
- Active cold sores, or infected or acne lesions at the treatment site
- A tendency to keloid scarring
- Clotting disorders or blood-thinning medication
- Allergy to hyaluronidase, bee or wasp venom, egg protein or lidocaine
- Immunosuppressant medication (ciclosporin, methotrexate, azathioprine)
- A history of cold sores where the lips are treated — antiviral cover (aciclovir) required
- Permanent fillers at the treatment site (e.g. Aquamid)
- Dental treatment within the last 14 days
- Air travel planned within 72 hours of treatment
- Oral retinoids (isotretinoin / Roaccutane) within the last 6 months
- Neuromuscular disorders such as myasthenia gravis (botulinum toxin)

Please answer YES or NO. Withholding information can lead to serious complications, including tissue necrosis and loss of sight.

Are you pregnant or breastfeeding?	☐ Yes	☐ No
Do you have an autoimmune condition (Hashimoto's, rheumatoid arthritis, lupus, MS)?	☐ Yes	☐ No
Do you have poorly controlled diabetes or any form of cancer?	☐ Yes	☐ No
Do you currently have an infection, a temperature or a cold?	☐ Yes	☐ No
Do you have an active cold sore or any infected lesion at the treatment site?	☐ Yes	☐ No

Do you have a tendency to keloid or hypertrophic scarring?	☐ Yes	☐ No
Do you have a clotting disorder or take blood-thinning medication?	☐ Yes	☐ No
Are you allergic to hyaluronidase, bee or wasp venom, egg protein or lidocaine?	☐ Yes	☐ No
Do you have permanent fillers at the treatment site (e.g. Aquamid)?	☐ Yes	☐ No
Have you had dental treatment in the last 14 days?	☐ Yes	☐ No
Are you flying within 72 hours of this treatment?	☐ Yes	☐ No
Have you taken retinoids (isotretinoin / Roaccutane, tretinoin) in the last 6 months?	☐ Yes	☐ No
Do you take immunosuppressant medication (ciclosporin, methotrexate, azathioprine)?	☐ Yes	☐ No
Do you get recurrent cold sores (particularly around the lips)?	☐ Yes	☐ No
Have you had botulinum toxin treatment before?	☐ Yes	☐ No

If YES — when was your last treatment?

Have you ever had a complication after a hyaluronic acid filler?	☐ Yes	☐ No

All medication you take regularly

☐ AGE: I confirm that I am aged 18 or over and that I have produced photographic ID (passport, driving licence or Maltese identity card) on request. I understand that this clinic does not treat anyone under 18 for cosmetic purposes and that a parent or guardian cannot consent to such treatment on my behalf.

PRESCRIPTION-ONLY MEDICINES: botulinum toxin is a prescription-only medicine under the Medicines Act (Chapter 458 of the Laws of Malta). It may only be prescribed for you personally by a registered prescriber (a doctor, dentist or nurse prescriber) following a consultation in person, and it may not be prescribed in advance for a group of clients. Hyaluronidase, the emergency treatment for a vascular occlusion caused by hyaluronic acid filler, is also a prescription-only medicine and must be held or accessible under a prescriber's direction. Dermal fillers are regulated as medical devices under Regulation (EU) 2017/745. You have been told who your prescriber is and how to reach the clinic in an emergency, including out of hours.

CRITICAL WARNING: vascular occlusion (filler blocking a blood vessel) can lead to TISSUE NECROSIS, LOSS OF SIGHT or STROKE. If an occlusion is suspected, I consent to immediate emergency management, which may include dissolving the filler with hyaluronidase administered by an appropriate prescriber, calling 112 and being taken straight to the nearest emergency department (accident and emergency) or emergency eye unit. I understand that hyaluronidase should be given within about 4 hours and that this may itself carry a risk of allergic reaction. I also understand that I have been offered a cooling-off period to consider this treatment and that I am not obliged to proceed today.

DATA PROTECTION NOTICE — The data controller is _____, registered address: _____, Company Registration No.: _____. Because we must understand your health in order to treat you safely, we process that information — special category data — on the basis of your explicit, freely given consent (Article 9(2)(a) GDPR). Without that consent the treatment cannot go ahead. Your records will be kept for 5 years from the end of the year of treatment, reflecting the prescriptive periods in the Civil Code (Chapter 16 of the Laws of Malta), and longer where a claim has been notified. You have the right to access, rectify or erase your data, to restrict or object to processing, and to complain to the Office of the Information and Data Protection Commissioner (IDPC) at idpc.org.mt.

Date

Client signature (consent and medical history)

Aftercare Advice and Emergency Protocol

AFTERCARE ADVICE AND EMERGENCY PROTOCOL — please read carefully and confirm each point. Not following this advice risks lasting complications, and in rare cases a medical emergency.

1. FOR 24 HOURS: do not touch or massage the injection sites, do not apply make-up, and do not wash the treated area with soap — use a mild cleanser only.

- [ ] I understand that I must not touch, massage or apply make-up to the area for 24 hours

2. FOR 48 HOURS: no alcohol (it increases swelling and bruising), no strenuous exercise, no saunas and no hot baths.

- [ ] I agree to avoid alcohol and strenuous exercise for 48 hours

3. FOR 14 DAYS: avoid saunas, sunbeds, extreme cold, dental treatment, facial massage and treatments using electrical currents or ultrasound.

- [ ] I agree to avoid saunas, sunbeds, extreme cold and competing treatments for 14 days

4. BOTULINUM TOXIN (if used): for 4 hours after treatment do not bend forward or lie flat. Avoid strenuous exercise and saunas for 24 hours. The full effect develops over 10-14 days, and a review appointment is usually offered at 2 weeks.

- [ ] I understand the aftercare advice for botulinum toxin (where applicable)

5. EMERGENCY PROTOCOL — VASCULAR OCCLUSION: sudden BLANCHING or a dusky, mottled or blue-grey appearance of the skin, severe or increasing pain out of proportion to the treatment, or any change in your vision are EMERGENCY SIGNS. Contact the clinic IMMEDIATELY on the number given to you. If you cannot reach us, call 112 or go straight to the nearest emergency department (accident and emergency), or an emergency eye unit for visual symptoms, and tell them you have had a hyaluronic acid filler. Hyaluronidase should be given within about 4 hours.

- [ ] I understand the emergency protocol: blanching skin, severe pain or any visual disturbance means contacting the clinic immediately and, if I cannot reach it, calling 112 or attending the nearest emergency department
- [ ] *I give my informed consent to the proposed treatment, having had its risks, side effects, likely results and the alternatives (including doing nothing) explained to me, and having had my questions answered*
- [ ] *I give my explicit and freely given consent to the processing of information about my health so that my suitability for treatment can be assessed and the treatment carried out safely (Article 9(2)(a) GDPR)*

INFORMATION: we will contact you after your treatment to check on your recovery and to arrange any review appointment. We do this on the basis of our legitimate interests in your safety and in the quality of our service (Article 6(1)(f) GDPR), and it does not require your consent. You may object to this contact at any time.

- [ ] *MARKETING CONSENT: I give my free and unpaid consent for _____ to use and publish photographs of my treatment (without showing my face or any identifying details) for promotional purposes on official social media profiles (including Instagram and Facebook) and the website. I may withdraw this consent at any time, and doing so will not affect any use made before withdrawal.*

DATA PROTECTION NOTICE — The data controller is _____, registered address: _____, Company Registration No.: _____. Because we must understand your health in order to treat you safely, we process that information — special category data — on the basis of your explicit, freely given consent (Article 9(2)(a) GDPR). Without that consent the treatment cannot go ahead. Your records will be kept for 5 years from the end of the year of treatment, reflecting the prescriptive periods in the Civil Code (Chapter 16 of the Laws of Malta), and longer where a claim has been notified. You have the right to access, rectify or erase your data, to restrict or object to processing, and to complain to the Office of the Information and Data Protection Commissioner (IDPC) at idpc.org.mt.

Date

Client signature (aftercare, emergency protocol and data protection)