

# MESOTHERAPY FAT DISSOLVING CONSENT FORM

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

I CONSENT TO MESOTHERAPY AND I ACCEPT THE SIDE AFFECTS THAT ARE POSSIBLE.

	INITIAL
Redness and swelling	_____
Bruising	_____
Infection	_____
Scars	_____
Localized and severe allergic reaction	_____
Pain and persisting pain	_____
Skin and fat necrosis	_____
Cardiac disturbance	_____
Failure and partial failure of procedure	_____
Other unexpected and further investigation treatments for these	_____
Loose skin	_____
Adjacent structure damage (nerve and vascular supply)	_____

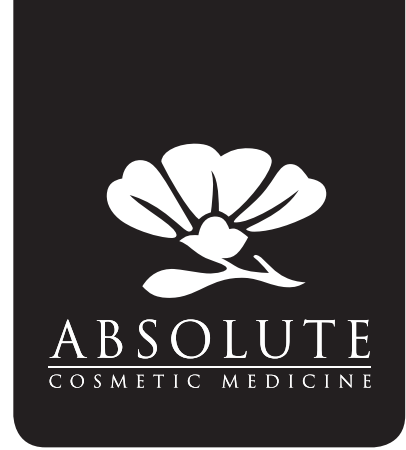
Having discussed the reasonable expectations of the mesotherapy with me, and having had all of my questions answered to my satisfaction, I authorise and direct Dr. Glenn Murray and the assistants of his choice to perform this procedure. I understand that the practice of medicine is not an exact science and although good results are expected, there can be no guarantee as to the outcome. I release Dr Murray and all associated staff from medico-legal liability.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I certify that I have discussed all of the above with the patient and have answered all questions regarding the procedure. I believe the patient fully understands what I have explained and answered.

DOCTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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