J. GOVRIN M.D.
Plastic Surgeon - Specialist
O.J. Govrin Refua LTD

ד"ר ג'קי גוברין
מנתח פלסטי - מומחה
א.ג. גוברין רפואה בע"מ

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מרפאות
חיפה - בית הרופאים, שד' בן גוריון 4
חיפה - רח' שארית הפליטה 13, דניה
נהריה - רח' סוקולוב 21

Consent form for the injection of filling materials of the type Perlane/Restylane

First name: _____ Last name: _____ ID no.: _____
I the undersigned request to be treated by an injection of Perlane at the site:

_____

I hereby testify that I have received a detailed oral explanation on the anticipated outcome, the possible risks and the alternative ways of treatment under the circumstances of the case, including the prospects and risks involved in each one of the procedures.
I am aware that Perlane has been in clinical use for several years and since it breaks down, long-term effects are not anticipated and not known. I was told that Perlane was approved for injection into soft tissues by the Ministry of Health and received the approval of the FDA in the USA.
I am aware that the substance will remain in the injection site for about a year; however, since the reactions in different people are different, this span of time varies from one person to another, and even in the same patient, the reaction is different at different times.
I consent to the administering of local anesthesia according to the physician's discretion.
I testify that I have received explanations and I understand that medicine is not an exact science, and it is not possible to foresee accurately the final outcome of the injection. Since people are not identical from the point of view of their anatomic structure and the properties of their skin, the response to the injection may differ from one person to another. Different reactions in various people may also ensue from the intake of different drugs. Since it is a question of factors that are not under the surgeon's full control, the outcome may be different in different people. Thus, I understand that is not possible to foresee accurately my reaction to the injection.
I am aware that the injection may result in adverse complications and side-effects such as: infections, bleeding at the site of the injection, swelling, pain, etc. The main potential complications of this injection are: asymmetry, not achieving the anticipated outcome, formation of lumps, bleeding, hyper-pigmentation, and infection
I realize that there may be also more rare complications and side-effects that usually do not take place, and since I did not ask for an explanation of these effects. I realize that it is not possible to evaluate accurately the optimal amount for injection, and it shall be done according to the best judgment of the operating physician, in collaboration with the patient.
I realize that any addition of a substance involves additional payment.
I consent to the taking pictures of my face or other parts of the body before and after the treatment as is customary in plastic surgery, and I am aware that they will be used for the purposes of science, documentation and follow-up.
I have received explanations that medicine and plastic surgery in particular, are not an exact science, and that it is not possible to prevent entirely complications and adverse outcomes. The surgeon undertakes to treat assiduously any complication or adverse outcome; however, it was made clear to me that no pecuniary indemnification of any kind will be awarded, for a post-operative complication or adverse outcome. Similarly, no coverage will be awarded for any pecu-

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niary or other damage incurred in connection with the treatment such as a loss of working days, purchasing of drugs, special trips, hospitalization, and/or any direct or indirect damage incurred in direct or indirect connection with the outcome of the treatment that I will receive.
My signature constitutes a free will confirmation and my request from the aforesaid physician to perform the aforesaid procedure.
Date: _____ Time: _____
First name: _____ Last name: _____
Signature: _____
I testify that I have explained all the aforesaid in the necessary detail and that she signed the consent in my presence, after I was satisfied that she understood fully my explanations.
Date: _____ Time: _____ Name of the physician: _____
Signature: _____