



Heather J. Roberts, M.D.

A Medical Corporation

Dermatology & Dermatologic Surgery
Cosmetic & Laser Surgery

Diplomate, American Board of Dermatology

Fellow, American Academy of Dermatology

American Society of Dermatologic Surgery

California Dermatology Society

The American Society for Laser Medicine and
Surgery

Skin Cancer Foundation

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Evolence Consent For Treatment

I, _____, authorize Heather J. Roberts, M.D. or _____ MD to inject Evolence into wrinkles, scars and/or contour defects.

Description: Evolence is a natural collagen that has been extensively purified in a lab from porcine tendon.

Indication: Evolence is FDA approved for the correction of moderate to deep facial wrinkles and folds, such as the nasolabial folds or "smile lines".

I understand the following warnings:

- 1) Evolence is contraindicated for patients with severe recurrent allergies manifested by difficulty breathing, swelling of the lips, tongue or throat.
- 2) Evolence contains porcine collagen and is contraindicated in patients with a history of allergies to such material.
- 3) Evolence will not be injected into sites of active infection or inflammation (rashes, cysts, pimples or hives) until such resolve.
- 4) Allergic reactions to Evolence have been observed with swelling, redness, tenderness, and rarely delayed onset inflammatory papules.
- 5) Temporary injection site reactions including redness, warmth, bruising, itch, swelling and discomfort have been observed but usually resolve spontaneously within 7 days.
- 6) As with all injections, Evolence treatment carries a risk of infection.
- 7) I have been advised that Evolence should be used with caution in patients with known keloid scar formation (ie raised, enlarged scars). To my knowledge, I have no history of keloids. Initial _____
- 8) I have been advised when appropriate not to take blood thinners (aspirin, Advil, Vitamin E, Fish Oil, Ginko, Garlic, etc.) for 2 weeks before treatment to decrease the risk of bruising or bleeding at injection sites. If bruising occurs, it may last up to 1 – 2 weeks. Application of vitamin K cream (available in our office for purchase) may speed healing.
- 9) Reactivation of pre-existing cold sores may occur at injection sites. I will notify Dr. Roberts of any such history prior to injection so that I may be given antiviral medication. Initial _____

To alleviate discomfort during the procedure, I may use topical anesthetic cream, injections of local anesthesia and possibly even a dental nerve block. I have been advised there may be minor temporary adverse effects from injectable anesthesia and/or nerve block such as numbness, swelling, hematoma, bruising, accidental biting of the tongue and/ or lips, difficulty moving the lips and smiling, pain and infection. Initial _____

Evolvece Consent For Treatment

(Continued)

I am not currently taking immune suppressing medications. Initial _____

I understand if I develop increased swelling, itching or spreading redness, I will immediately call Dr. Roberts.

I understand that Evolvece is an FDA approved temporary dermal filler that will require periodic "touch-ups" to maintain maximum correction.

I agree that during the first 24 – 48 hours following injection or until all redness and swelling are gone, I will avoid:

- 1) Extensive sun or heat exposure, including tanning salons
- 2) Alcoholic beverages
- 3) Extreme cold weather
- 4) Strenuous exercise

I understand that exposure to 1) – 4) may cause temporary but prolonged swelling, redness and/or pain at injection sites. Initial _____

I understand the safety of Evolvece injections during pregnancy is unknown. I am not aware that I am currently pregnant. Initial _____

I understand this procedure is considered cosmetic and further understand that it will not be covered by my health insurance. Payment in full is due on the day of service. My insurance may or may not cover the cost of treatment if any complications should arise. Initial _____

I have read the "Evolvece Consent for Treatment" in its entirety and have discussed the risks, benefits and alternatives of these injectable fillers with Dr. Roberts or _____.

By my signature below, I acknowledge that I have read the "Consent for Evolvece Consent for Treatment" and understand it. I have been given the opportunity to ask questions. My questions have been answered fully to my satisfaction. I have been adequately informed of the risks and benefits of this treatment and wish to proceed.

Patient Signature _____ Date _____

Guardian Signature (if patient is a Minor) _____

Relationship to patient _____

Witness Signature _____ Date _____