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# Electronic Certificate

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**Document Name:** Restylane Treatment Record Form (new logo)_Previously approved in zincmaps

**Country:** Singapore

**Brand:** Restylane

**Type:** Material

**Sub Type:** Patient Consultation Form

**Audience:** General Practitioner Healthcare Provider Medical Specialist Nurse

**Type of HCP:**

**Further Audience Information:**

**Method of Dissemination:** Ax HCP Portal Digital GAIN Connect Asset Library

**Submission Required:**

**Certification Statement**

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| Role | Signature |
|---|---|
| Cherie Yip - Reapprove (cherie.yip@galderma.com) | Meaning: As the Regulatory Approver, I approve this document for use.<br>Date: 02-Oct-2023 06:43:39 GMT+0000 |

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# Treatment Record Form

## MEDICAL HISTORY

### PRECAUTIONS

*Please tick* ✔

| | Yes | No |
|---|---|---|
| Is there any possibility that you are pregnant? | ☐ | ☐ |
| Are you breast feeding? | ☐ | ☐ |
| Have you recently been injected with anything in your face | ☐ | ☐ |
| *If yes, where?* ..... | | |
| Do you have any permanent implant(s) in your face? | ☐ | ☐ |
| Have you undergone laser treatment or received a skin peel in the past six weeks? | ☐ | ☐ |
| Do you suffer from facial herpes, cold sores or any active skin conditions, e.g. acne or psoriasis? | ☐ | ☐ |
| Do you have or have you ever had any form of skin cancer? | ☐ | ☐ |
| What are your expectations of the outcome of the treatment? | | |
| ..... | | |

### CONSIDERATIONS

| | Yes | No |
|---|---|---|
| Have you previously experienced hypersensitivity to hyaluronic acid, filler injections or Restylane products? | ☐ | ☐ |
| Have you ever experienced any hypersensitivity to lidocaine (a local anesthetic)? | ☐ | ☐ |
| Have you received oral isotretinoin or topical tretinoin treatments in the past 12 months? | ☐ | ☐ |
| Do you suffer from any known allergies? | ☐ | ☐ |
| *If yes, please specify?* ..... | | |
| Do you have a history of anaphylactic shock (severe allergic reactions resulting in difficulty breathing)? | ☐ | ☐ |
| Are you taking aspirin, steroids or anticoagulants? | ☐ | ☐ |
| *If yes, please specify?* ..... | | |
| Are you currently taking any other medication? | ☐ | ☐ |
| *If yes, please specify?* ..... | | |
| Do you suffer from any illnesses, e.g. angina, epilepsy, diabetes, HIV positive, hepatitis, auto immune disease (e.g. rheumatoid arthritis), depression, stress? | ☐ | ☐ |
| *If yes, please specify?* ..... | | |
| Have you recently undergone major surgery? | ☐ | ☐ |
| *If yes, please specify?* ..... | | |
| Are you currently undergoing dental surgery? | ☐ | ☐ |
| Do you suffer from fainting or low blood pressure? | ☐ | ☐ |
| Are you prone to keloids or hypertrophic scarring? | ☐ | ☐ |
| Do you have a fear of needles? | ☐ | ☐ |
| Are you prone to bruising? | ☐ | ☐ |
| Have you recently been exposed to the sun or sun beds? | ☐ | ☐ |

**IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES" THE PRACTITIONER MAY DECIDE THAT YOU ARE NOT SUITABLE FOR TREATMENT.**

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# PATIENT TREATMENT RECORD FORM

Last Name _____ First Name _____ Last 4 digits of NRIC _____

Gender _____ Date of Birth (dd-mm-yy) _____ Ethnicity _____

History/Previous Treatment _____ Clinic Name & Address _____

_____

_____

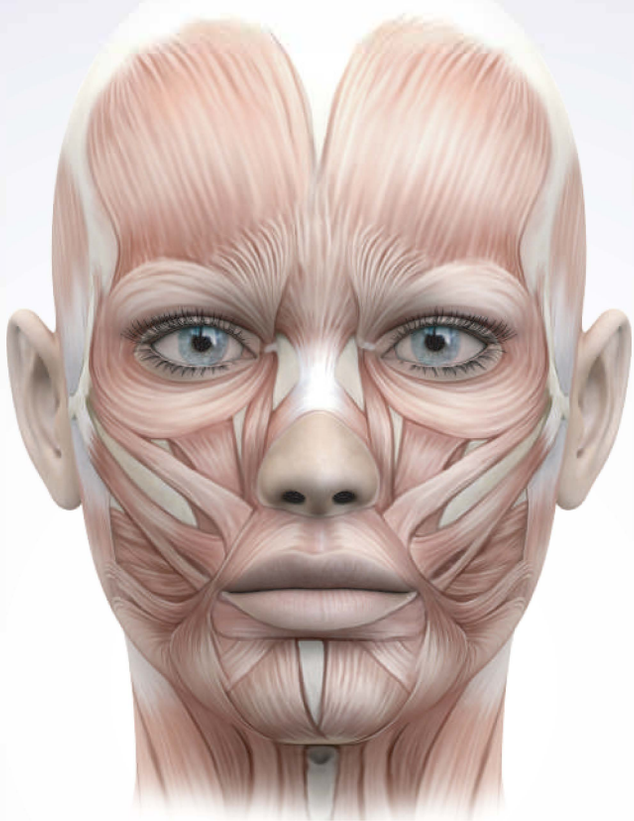
_____

# TREATMENT SUMMARY

Treatment session #_____ (state number)

Amount Injected (mL)

Area Injected



Treatment notes: _____

_____

_____ Type of anaesthesia used: _____

Doctor's Name _____ Doctor's Signature _____ Date of treatment _____



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