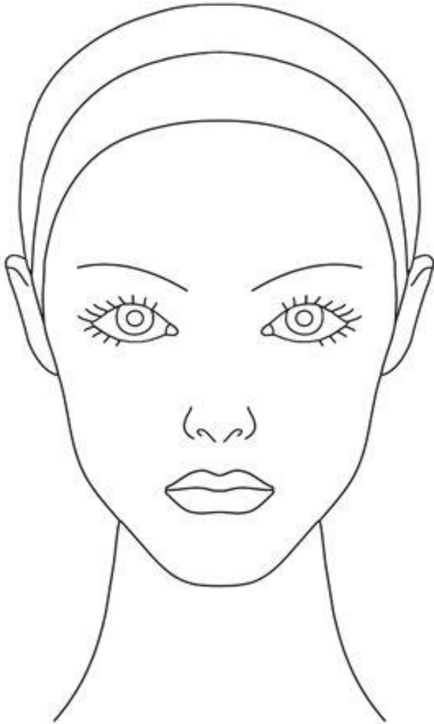
INJECTABLE TREATMENT RECORD



Patient Name: ___________________________________

Date: _______________________________________

Medical History Reviewed: YES / NO

Patient seen by MD/NP for Consultation: YES / NO

Physician/NP Order Obtained: YES / NO

Verbal & Written Informed Consent Obtained: YES / NO

Pre & Post Treatments Instructions Reviewed: YES / NO

Total Neurotoxin Units: _______ Lot #:____________

Total number of filler syringes: __________

Treatment Notes:

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Lot # Stickers for Fillers