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Comprehensive Care Centre for Movement Disorders,
Department of Neurology

AFFIX PATIENT LABEL HERE

CONSENT FORM FOR BOTULINUM TOXIN INJECTION

Diagnosis:_____

I have been advised that **botulinum toxin injection** is being considered for the treatment of my neurological symptoms. I understand that Botulinum toxin acts by temporarily weakening the injected muscles and reducing excessive activity, thereby relieving symptoms such as abnormal posturing, involuntary movements, spasms, or pain.

I have been told that **the effects are temporary**, usually lasting **several weeks to a few months**, after which the symptoms may gradually return and repeat injections may be required. The duration and degree of benefit vary between individuals and may change with successive injections. Some patients may not get any satisfactory benefit from some injection sessions.

I have understood that doctors will make every possible effort to minimise any side effects and complications, but in some cases, they may occur despite all the precautions taken. I was informed that the side effects include local effects like (1) Pain, discomfort, and bleeding at the injection site (2) swelling or tenderness at the site (3) Infection at the injection site and (4) allergic reactions including respiratory complications and cardiac problems which could be potentially fatal (rare) (5) Injury to the nerves in the neck, leading to pain or weakness of hands or injury to the upper part of the lungs (Rare; with neck injections)

I have been clearly informed that temporary weakness of the injected muscle or nearby muscles is a side effect that needs to be specifically anticipated in patients receiving Botulinum toxin Injections. The weakness could occasionally be more than intended and may interfere with normal activities for a few days to weeks (Rarely, even months).

I understand that the dose and injection sites are selected to balance the desired therapeutic effect against the risk of excessive weakness, but side effects cannot always be completely avoided.

The weakness could manifest as drooping of eye lids, double vision, inability to close the eyes completely, or dryness of eyes (particularly when the injection is taken around the eyes or on face) facial weakness and deviation of face to one side and drooling of saliva (when injected on the face) neck weakness leading to inability to hold the neck straight, and difficulty to swallow (when neck muscles are injected), difficulty in chewing,

opening or closing the mouth (when jaw is injected), difficulty in speaking (with Injections of the tongue) weakness of hand (when the forearm or hand is injected for conditions like Writer's cramp) and weakness of the lower limb (when lower limb muscles are injected). I also understand that the toxin may rarely affect muscles distant from the injection site, resulting in more generalised weakness or other symptoms. For example, a lower-limb injection could rarely cause swallowing problems or double vision or, rarely, breathing difficulty.

I understand that the weakness will recover on its own, but it may take a few weeks or months. I have been informed that there is no antidote for the drug to reverse the weakness, and I have to patiently do physiotherapy or other similar measures and wait for a natural recovery. During this period, I may have to modify my activities or seek help from someone. I have also been informed that the swallowing difficulty from botulinum toxin injections needs to be managed as an emergency, as the resulting choking during feeding can sometimes lead to dangerous consequences. If swallowing difficulty occurs (with neck injections or even with injections at other sites, rarely), a nasogastric tube may need to be inserted for feeding till the weakness and swallowing difficulty improve

I voluntarily give my consent for Botulinum Toxin injection **after understanding all the above aspects and after clearing all my doubts with my doctor.**
I also understand that this injection will have to be repeated at specific intervals and such re-injections may have to be continued indefinitely. All the above facts also apply to re-injections. My consent for the Injection, after understanding all the above facts, is for all future injection sessions, and my review visits to the Injection Clinic mean that my consent given for the Injection remains valid.

	Name	**Signature / Thumb impression**	**Date**	**Time**
Patient / Authorised relative (LAR)	Relationship with patient (if LAR):		DD/MM/YYYY	HH:MM AM/PM
Witness (Relative) if available			DD/MM/YYYY	HH:MM AM/PM
In the presence of Dr.			DD/MM/YYYY	HH:MM AM/PM