



DERMATOLOGY  
ASSOCIATES OF ITHACA  
*Healthier Skin Since 1983*

## DID YOU KNOW?

Wrinkles result from a combination of many factors. It's not just about cellular changes that can occur over time, reduction of collagen, or damage caused by free radicals in the sun and environment.



RESTYLANE® works by adding back.



**Ithaca:** 1051 Craft Road  
**Cortland:** 3773 Luker Rd.  
T: 607-257-1107  
F: 607-257-0369  
[www.ithacaderm.com](http://www.ithacaderm.com)

# RESTYLANE®

RESTYLANE® is a hyaluronic acid filler that can smoothen out wrinkles and skin folds, add volume to the lips, and rejuvenate facial features that have lost their fullness due to aging, sun damage, illness, etc. Hyaluronic acid fillers are the most popular type of filler in the US market. Because hyaluronic acid is naturally found in the second layer of skin, providing hydration, fullness and elasticity, there is no allergy testing needed. The effects of RESTYLANE® may last 6 months to 2 years.

## PROCEDURE DESCRIPTION

Each treatment takes approximately 30 minutes. Your provider will inject the areas needing lifting and smoothening, with results that may be seen immediately.

## RISKS / COMPLICATIONS

Immediate redness, swelling and bruising may occur at each injection site. Other possible side effects include: embolization of the filler material, pain or tenderness, palpable outline of the filler, infection, discoloration, allergic reaction, itching, ulceration, and scar. These side effects are rare, but have been reported.

Cold sores can be triggered by any facial procedure. If you have a history of cold sores, be sure to notify your provider prior to your procedure so you can be given medication to reduce the chance of a breakout.

There is no guarantee of results, and though it is unlikely, there may be minimal or no improvement of the condition.

## CONTRAINDICATIONS

- Pregnancy or Nursing
- History of connective tissue disease, such as lupus, morphea, or scleroderma
- History of keloid scarring

## BEFORE Your RESTYLANE® Treatment

- **Aspirin and ibuprofen should be avoided 10-14 days prior** to minimize risk of bruising. **If you have been told to take aspirin daily by your doctor, please let us know before stopping it.** Other medications to avoid include **Excedrin™, Motrin™, Naprosyn™, Aleve™, Gingko, garlic supplements, fish oil, and Vitamin E.**
- **Avoid alcohol 2 days prior to treatment** to minimize risk of bruising.
- If you have a history of **cold sores**, please let us know before the day of the procedure so a medication can be given to reduce an outbreak.
- Be sure that you have communicated any pertinent medical history to your provider, particularly any history of autoimmune disease, medication allergies, new medications, pregnancy, breastfeeding, and previous cosmetic procedures.

## AFTER Your RESTYLANE® Treatment

- **Aspirin and ibuprofen should be avoided for 2 days after** to minimize risk of bruising.
- Avoid massaging the areas, lying down, or bending for the next 4 hours.
- Avoid excessive exposure to sunlight or cold in the day following the procedure.
- After the procedure you may reapply makeup and resume your skin care routine.

## CONSENT TO YOUR RESTYLANE® TREATMENT

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

1. I consent to the performance of RESTYLANE® injection.
2. The procedure has been explained to me including the benefits of the treatment, risks involved, and possible alternative methods of treatment. I have had the opportunity to discuss this procedure and have received answers to all questions I asked.
3. I understand that there is no guarantee that any particular results will be obtained.
4. I authorize the taking of clinical photographs to assess the effect of treatment and for possible use for marketing, patient education and scientific purposes. I understand my identity will be protected.

**I have read the above and understand it. My questions have been answered satisfactorily by the doctor and doctor's associates. I accept the instructions, risks and complications of the procedure.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date