Injectable Treatment Record Card

laserclinics

Name: Prescriber:

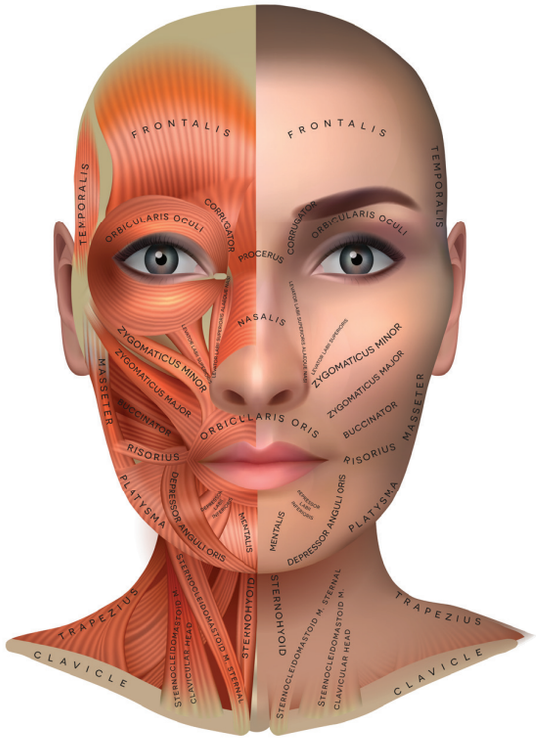
D.O.B / /

Medical History

Date of initial consultation / /

Clinic

AIMS	☐ Soften with movement	☐ Remove lines not frozen	☐ Frozen
PREVIOUS TREATMENT	☐ None	☐ Yes, last treated / /	
PREVIOUS DOSES USED IN PRIOR TREATMENTS?			
CONSENT	☐ Discussed	☐ Verbal consent obtained	
PATIENT AGREED TO PHOTOS	☐ Yes, for patient files only	☐ Yes, incl. unidentifiable	☐ Yes, any capacity
	☐ **MH CHECKED**	☐ **CONSENT OBTAINED**	
AREA TREATED	☐ Botox	☐ Filler	



TOXIN	AREA 1	AREA 2	AREA 3	AREA 4
TREATMENT DATE				
Dilution (mL)				
Units / 0.1mL				
LOCATION				
LOT NUMBER				
EXPIRATION DATE				
TOTAL UNITS USED				
FILLER	**AREA 1**	**AREA 2**	**AREA 3**	**AREA 4**
TREATMENT DATE				
LOCATION				
LOT NUMBER				
EXPIRATION DATE				
TOTAL MLS USED				

2 week reminder / /

Quote: $

Client Signature

Injector Signature