フィラー溶解（ヒアルロニダーゼ）同意書

ヒアルロン酸フィラーをヒアルロニダーゼで溶解することに関する事前同意書（アレルギー検査および不完全または過度な補正の可能性を含む）

クライアント情報

First Name *

Last Name *

Email Address *

Phone Number *

Date of Birth *

YYYY年MM月DD日

治療詳細

Areas to be dissolved *

- ☐ Lips
- ☐ Cheeks / Midface
- ☐ Under-eye / Tear trough
- ☐ Chin / Jawline
- ☐ Nose
- ☐ Other

Reason for dissolving *

- ☐ Aesthetic — unhappy with result
- ☐ Migration or lumps
- ☐ Suspected vascular complication (urgent)
- ☐ Preparing for a new treatment

What filler was injected, where, and when?

Have you had hyaluronidase before? *

- ☐ Yes
- ☐ No

If yes, did you have any reaction?

医歴

Are you pregnant, trying to conceive, or breastfeeding? *

- ☐ Yes
- ☐ No

Do you have any of the following?

- ☐ Autoimmune condition (lupus, RA, MS, etc.)
- ☐ Bleeding disorder or on blood thinners
- ☐ Diabetes
- ☐ History of keloid or hypertrophic scarring
- ☐ Cancer (current or within the last 5 years)
- ☐ Immunosuppressed / immune disorder
- ☐ None of the above

Are you allergic to bee or wasp stings? *

☐ Yes ☐ No

Have you ever reacted to hyaluronidase or a product containing it? *

☐ Yes ☐ No

Do you have any non-hyaluronic acid or permanent filler in the area (e.g., Radiesse, Sculptra, silicone)? *

☐ Yes ☐ No

Current medications and supplements

Allergies (medications, latex, lidocaine, anesthetics)

リスクと合併症

Potential Risks and Complications:

- Allergic reaction, including hives, swelling, or in rare cases anaphylaxis (a patch test may be performed first)
- Over-dissolving — loss of your own natural hyaluronic acid can cause temporary hollowing or laxity, usually recovering within weeks
- Incomplete dissolving — more than one session may be needed
- Bruising, swelling, tenderness at injection sites
- Asymmetry while the area settles
- Infection (rare)

Only hyaluronic acid fillers can be dissolved. Results of a future re-treatment are not guaranteed, and re-filling is usually deferred for at least 2 weeks.

I understand that hyaluronidase may dissolve more or less filler than intended, that my natural tissue volume may temporarily change, and that additional sessions or later re-treatment may be needed.

I understand the treatment may over- or under-correct: _____

I understand that hyaluronidase is an enzyme that can cause allergic reactions and that I must report itching, hives, facial swelling, or breathing difficulty immediately.

I understand the risk of allergic reaction: _____

写真利用許可

May we take before-and-after photos for your treatment record? *

- ☐ Yes — for my medical record only
- ☐ Yes — and you may use them anonymously for marketing
- ☐ No

サービスログ
オフィス使用のみ

Service Log

	Date	Area	Product / Lot #	Dose / Volume
Entry 1				
Entry 2				
Entry 3				
Entry 4				
Entry 5				
Entry 6				

同意と署名

I voluntarily consent to hyaluronidase injection to dissolve hyaluronic acid filler. I have been informed of the benefits, risks, alternatives, and potential complications. I understand that no guarantee has been made about the final appearance of the treated area, that a patch test may be performed, and that I may need further sessions. I release the provider and practice from liability related to this treatment except in cases of negligence.

I confirm I have read and understood the above information and give my informed consent.

I have read and understand the above information: _____

Signature

日付

名前を記入

Date *

YYYY年MM月DD日