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BOTULINUM TOXIN FOR DYSTONIA AND OTHER DISORDERS

PATIENT CONSENT

Patient's Last Name: _____ First Name: _____

I authorize Dr. Joseph Jankovic and/or his associates of his choice to treat me with the proposed medication with the hope of improving my spasms (dystonia or other movement disorder) or other conditions. Botulinum toxin type A (BOTOX[®]) has been approved by the Federal Food and Drug Administration (FDA) for the treatment of blepharospasm, hemifacial spasm, and cervical dystonia and botulinum toxin type B (MYOBLOC[™]) for cervical dystonia. Once approved by the FDA the medication, however, can be used for other, yet not approved conditions ("off-label"), based on the judgment of the treating physician. There is some discomfort associated with the injection. Potential complications may include weakness of the injected muscles and other unknown side effects. In patients treated for blepharospasm the most common side effects have included droopy eyelids and blurring of vision. Swallowing problems lasting a few days and up to several weeks occasionally occur after injections into jaw, vocal cord, and neck muscles. Every precaution will be taken to avoid any serious side effects by using safe dosages, avoiding systemic circulation, and performing repeated clinical evaluation.

My signature below constitutes my acknowledgment that I have read and agreed to the foregoing, the proposed treatment has been satisfactorily described to me, all my questions have been answered to my satisfaction, and I have the right to ask additional questions at any time. I hereby agree to follow the directions prescribed by my doctor and will report side effects to the doctor. I am free to withdraw from this treatment program at any time and may be terminated from the program by Dr. Jankovic and/or his associates at his or their discretion. My participation in this treatment program is voluntary, and I will not be financially compensated for the loss of time at work, travel, etc. The cost of this treatment will be my responsibility. I understand that I will be followed at regular intervals and will report to the Movement Disorders Clinic at appointed times.

I grant this authority and consent voluntarily and with no assurances as to the results.

SIGNATURE OF PATIENT/GUARDIAN

DATE

SIGNATURE OF WITNESS

DATE