Dear Physician,

We appreciate your willingness to complete the following Patient Complications Report. It is the intent of the American Society for Dermatologic Surgery Association (ASDSA) to compile the data from the Reports it receives and use it, in aggregate form, for purposes of furthering the ASDSA’s legislative and regulatory advocacy efforts, as well as for reporting on, and informing physicians, policymakers, and the general public about, patient complications from cosmetic medical procedures performed by non-physicians.

The Report does not need to be filled out completely. Please fill in only such information that you are authorized to provide and return the Report by fax to ASDSA at 847/956-0999, by email to lsoukup@asds.net or by mail to the American Society for Dermatologic Surgery Association, Patient Complications Report, 5550 Meadowbrook Drive, Suite 120, Rolling Meadows, IL 60008.

If the patient is willing to provide photographs documenting his/her complication, we would appreciate your advising him/her that such photographs may be submitted directly to the ASDSA pursuant to a signed Authorization and Release, a copy of which is included as the last page of this document or may be downloaded from the ASDSA website at www.asds.net.

Thank you for your participation,
ASDSA Board of Directors
Section 1. This section may be completed by the physician treating the complication and/or the physician’s office personnel, with assistance from the patient.

Patient’s Gender: Male ______ Female ________

Patient’s Year of Birth: __________

Type of procedure:
____ Botulinum toxin injection: Type of botulinum toxin: ________________________________
____ Filler injection: Type of filler: _______________________________________________
____ Laser or light-based
____ Ultrasonic Fat/Cellulite Reduction
____ Radiofrequency Skin Tightening
____ Chemical Peel
____ Tumescent Liposuction
____ Mesotherapy/Lipodissolve
____ Other (please specify): _______________________________________________________

Type of facility at which the procedure was performed:
____ Physician’s office
____ Hospital
____ Outpatient facility
____ Medispa
____ Salon
____ Practitioner’s home
____ Other (please describe): _____________________________________________________

Training of practitioner who performed the procedure:
____ Licensed physician
____ Licensed physician’s assistant
____ Licensed registered nurse
____ Licensed nurse practitioner
___Cosmetologist
___Electrologist
___Medispa staff (none of the above)
___Salon staff (none of the above)
___Do not know
___Other (please describe): _____________________________________________________

Did a licensed physician conduct the initial examination and recommend the procedure?
___Yes

    Specialty of the physician who conducted the examination
    ___Dermatologist
    ___Plastic surgeon
    ___Family physician
    ___Other (please describe): ___________________________________________________
    ___Don’t know

___No
___Don’t know if it was a licensed physician

Was a physician onsite during the procedure?
___Yes

    Specialty of the physician onsite during the procedure
    ___Dermatologist
    ___Plastic surgeon
    ___Family physician
    ___Other (please describe): ___________________________________________________
    ___Don’t know

___No
___Don’t know

Did the physician evaluate the patient (please check all that apply):
___Before the procedure
___During the procedure
___ After the procedure
___ None of the above
___ Patient doesn’t recall

Was the patient advised of potential dangers, side effects or complications that could occur as a result of the procedure?
___ Yes
___ No
___ Patient doesn’t recall

On what basis did the patient select the original practitioner?
___ Advertisement
___ Print (newspaper or magazine)
___ Internet
___ Television
___ Radio
___ Phone Book
___ Referred by a friend or family member
___ "Won" a free consultation
___ Other (please describe):_____________________________________________________
___ Patient doesn’t recall

Had other procedures been performed on/other treatment provided to the patient by the original practitioner/facility prior to the procedure for which he/she now presents a complication?
___ Yes
    Please describe the kind of treatment _________________________________________
___ No
___ Patient doesn’t recall

Did the patient miss work or school as a result of the complication?
___ Yes
    Please indicate number of days missed:_________
___ No
___ Patient doesn’t recall
Did the patient first return to the original practitioner/facility to address the complication?
___ Yes
___ No
___ Patient doesn’t recall

Did the patient receive emergency room treatment as a result of the complication?
___ Yes

Was the patient admitted to the hospital as a result of the complication?
___ Yes
___ No
___ No
___ Patient doesn’t recall

Will the patient’s insurer cover the cost of treating the complication?
___ Yes
___ No
___ Don’t know

Has the patient reported this complication to his/her state medical board or another regulatory agency?
___ Yes
    To which regulatory agency was the complaint reported? ______________________________
___ No
Section 2. This section should be completed by the physician treating the complication.

Please describe the complication.

Please indicate the severity of the complication:

___ May have contributed to or resulted in temporary harm to the patient and required intervention
___ May have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization
___ May have contributed to or resulted in permanent patient harm
___ Required intervention necessary to sustain life
___ May have contributed to or resulted in the patient's death

Please indicate your estimation as to the cause of the complication (please check all that apply):

___ Inappropriate treatment for the patient's condition
___ Inappropriate treatment for the patient's skin type
___ Ineffective treatment
___ Skin cancer misdiagnosis
___ Poor technique on the part of the practitioner
___ Adverse drug combination
___ Equipment or device malfunction
___ Contamination of drug or equipment
___ Counterfeit drug
___ Non-FDA approved treatment
___ Don't know
___ Other

Please describe the conditions leading to the complication presented, follow-up treatment (proposed or provided), and known or anticipated long-term effects (if any).
PLEASE READ AND SIGN:

PHYSICIAN CONSENT

I represent and warrant that I have complied with any and all patient privacy laws applicable to the provision of my submitted information. If the patient is willing, he/she shall submit photographs documenting his/her complication directly to the ASDSA pursuant to a signed Authorization and Release. I understand that the information provided may be used for purposes of furthering the ASDSA’s legislative and regulatory advocacy efforts and for otherwise reporting on, and informing physicians, policymakers, and the general public about patient complications from cosmetic medical procedures performed by non-physicians, and I consent to the publication, distribution, and other use of my submitted information for these or any other related purposes. I further represent and warrant that my submission is accurate to the best of my knowledge, that it does not violate any copyright, proprietary or personal rights of others, that I have not previously granted any rights to other parties that are inconsistent with this Physician Consent, and that I have the authority to grant this Physician Consent.

I understand that the ASDSA’s publication, distribution, or use of the information does not constitute its endorsement, approval, or recommendation of me or any products, processes, or services I have provided to the patient. I further understand that ASDSA undertakes no obligation to publish the information.

I hereby indemnify and hold the ASDSA, its directors, officers, members, employees, and agents harmless from and against any and all claims, expenses (including reasonable attorneys’ fees), and liabilities whatsoever arising, directly or indirectly, from any breach of my representations in this Physician Consent. I further waive any and all rights I may have against the ASDSA, its directors, officers, members, employees, and agents, and release and discharge them from any claim relating to my submission.

I grant this Physician Consent as a voluntary contribution to the ASDSA in the interest of public education and waive any claim for payment in connection with such Physician Consent.

I certify that I have read the above Physician Consent and fully understand its terms.

Physician name (please print): _________________________________

Physician signature: __________________________________________

Date: ____________

Please return this Report by fax to ASDSA at 847/956-0999, by email to lsoukup@asds.net or by mail to American Society for Dermatologic Surgery Association, Patient Complications Report, 5550 Meadowbrook Drive, Suite 120, Rolling Meadows, IL 60008.
Authorization and Release

I represent and warrant that I have authorized my physician, ______________________, to submit to the American Society for Dermatologic Surgery Association (ASDSA) a Patient Complications Report (Report) regarding the complications that I experienced following the performance of the cosmetic procedure described in the Report. I am providing the enclosed photographs further documenting that procedure (Photographs), and I hereby authorize and request the publication, distribution and other use of such Photographs under the following terms and conditions.

1. The ASDSA, or a third party designated by the ASDSA, may publish, distribute, or otherwise use the Photographs for purposes of furthering the ASDSA’s legislative and regulatory advocacy efforts, as well as for reporting on, and informing physicians, policymakers, and the general public about, patient complications from cosmetic medical procedures performed by non-physicians.

2. The Photographs may be published, distributed, or otherwise used, either alone, or in conjunction with information provided in the Report, in any visual print or electronic media, specifically including, but not limited to, Web sites, medical journals, position papers, textbooks, newspapers, and magazines. The ASDSA undertakes no obligation to publish the Photographs.

3. The Photographs may identify or otherwise present a recognizable likeness of me, and I may be named in a publication. The Photographs may be modified in any way that the ASDSA or its designees may consider appropriate to achieve the purposes for which, or comply with the limitations subject to which, this Authorization and Release is given.

4. I represent and warrant that I am the sole owner of the Photographs. I hereby grant ASDSA a non-exclusive, transferable, unrestricted license to publish, distribute and otherwise use the Photographs for the purposes set forth above. I further represent and warrant that this license does not violate any copyright, proprietary or personal rights of others, that I have not previously granted any rights to other parties that are inconsistent with the rights herein granted to the ASDSA, and that I have the authority to grant this license.

5. I hereby waive any and all rights I may have against the American Society for Dermatologic Surgery Association, its officers, directors, members, employees, and agents and release and discharge them, their designees, and all parties acting under their authority from any and all claims that I may have relating to the publication, distribution, or other use of the Photographs and the related Report, including, without limitation, any claim for payment in connection with such use.

6. I grant this Authorization and Release as a voluntary contribution to the ASDSA in the interest of public education and certify that I have read it and fully understand its terms.

__________________________________  ________________________________
Signature      Date

__________________________________
Name (Please Print)

WITNESS: ____________________________________