DermaSculpt
MEDICAL AESTHETICS
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Date: _____

Therapeutic Botulinum Toxin (Botox®) & PRP Joint Injection Referral Form

Patient Information

Full Name: _____ Date of Birth: _____ / ____ / _____
Address: _____
Phone #: _____ Email: _____
Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Section A: Therapeutic Botulinum Toxin (Botox®) – Reason for Referral:

☐ Primary focal hyperhidrosis: ☐Axillary ☐Palms ☐Soles ☐Scalp
☐ Chronic migraine (≥15 headache days/month)
☐ Temporomandibular disorder / bruxism
☐ Plantar fasciitis or heel pain
☐ Myofascial pain (e.g. trapezius hypertrophy/spasm)
☐ Other (specify): _____

Relevant Medical History (if known):

☐ Symptoms refractory to conservative therapy
☐ Prior topical / oral therapies attempted
☐ Prior Botox treatment with benefit
☐ No known neuromuscular disorder (e.g. myasthenia gravis)
☐ Not pregnant or breastfeeding
Severity score or frequency (if applicable): _____

Section B: Platelet-Rich Plasma (PRP) Joint Injection Referral

Joint(s) / Area(s): _____
Primary diagnosis (if known): ☐ *OA* ☐ *Tendinopathy* ☐ *Ligament injury* ☐ *Other*
☐ No active infection at injection site
☐ No bleeding disorder or therapeutic anticoagulation
☐ Platelet count adequate (if known)

Relevant Medical History / Medications:

_____
_____

Referring Provider Information

Provider: _____ Address: _____
Phone #: _____ Fax #: _____
Provider Signature: _____

Please fax completed referral form to 1-877-762-1217