

Injection Details

To be completed by the physician

Name
DOB
Chart No.
Current Date
Examiner

1 Indication for Injection

<input type="checkbox"/> Dystonia	<input type="checkbox"/> Tremor	<input type="checkbox"/> Pain
<input type="checkbox"/> Hemifacial spasm	<input type="checkbox"/> Tics	<input type="checkbox"/> Other _____
<input type="checkbox"/> Spasticity	<input type="checkbox"/> Hyperfunctional facial lines	

2 Substance injected: BTX _____units/mL Phenol _____%

Muscle (see list on reverse)	Units/Inj	Vol/Inj	# of Inj	Total Units	Total Vol
<input type="checkbox"/> Y <input type="checkbox"/> N Electromyography utilized for muscle identification?				Total Amount Administered	
<input type="checkbox"/> Y <input type="checkbox"/> N Stimulation utilized for muscle identification?				Total Amount Used	

3 Physician's Comments

Physician's Signature _____ Date _____

