DR. EDA KİBAR DERMATOLOGY CLINIC

PATIENT INFORMATION AND INFORMATIVE CONSENT FORM

Information Date : …./…. /…...

PROCESS INFORMATION

PROCESS NAME	**: DERMAL FILLING**
REASON OF PLANNING THE PROCESS	**:**
INFORMATION DATE AND TIME	**:**

PATIENT INFORMATION

NAME&SURNAME	
PASSPORT NO	
BIRTH DATE	
ADDRES	
TELEPHONE NO	
E-MAİL	

Dear Patient, PLEASE READ THIS FORM CAREFULLY

- It is your most natural right to be informed about your medical condition and the proposed procedure/treatments for the diagnosis and treatment of your disease. The purpose of these explanations is to inform you about your health issues and to participate in this process more consciously.
- It is up to your personal decision to consent or not to consent to the procedure after learning about the benefits and possible risks of medical treatment.
- The purpose of this form is to inform you about the benefits, risks, undesirable results (complications) of the **Dermal Filling** that is planned to be applied, and what needs to be considered before and after the procedure, to ensure that you understand this procedure to be applied to you and give your consent with your own decision.
- If you have questions or points that you do not understand, state them and ask your doctor for help.
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- You can allow a person you designate to participate in the process of consenting to the actions to be taken against you as a witness to the interview.

Dr. Eda Kibar
Exclusive Dermatology & Aesthetic

Please fill in the fields below completely

Do you have a chronic disease that requires or does not require continuous treatment?	Yes	No
Are there any medications you use regularly?	Yes	No
Do you have previous hepatitis B, hepatitis C, syphilis, HIV(+)?	Yes	No
Have you been diagnosed/treated for cancer?	Yes	No
Are you pregnant or breasfeeding? Is there any risk of pregnancy?	Yes	No
Do you have active skin disease?	Yes	No
Do you have a tendency to bleed?	Yes	No
Have you recently taken aspirin, blood thinners, green tea, coenzyme Q etc. or any nutritional supplements?	Yes	No
Do you have a systemic or local infection in the application area?	Yes	No
Do you experience recurrent herpes infection?	Yes	No
Have you had any previous surgery/s?	Yes	No
Do you have a history of allergies?	Yes	No
Do you use a cosmetic product on the application area?	Yes	No
Have you been exposed to intense sun or ultraviolet (with solarium device)? If yes, please specify when was the last: ……	Yes	No
Do you have a history of panic attacks?	Yes	No

Write in detail the situations, in which you answered yes to the questions asked, in the field below. If there are situations (any other disease, etc.) that you want to explain other than those asked, please explain in the space below.

1- METHOD OF APPLICATION OF THE PROCEDURE

Before the procedure, anesthetic agent is applied by cream or injection method. After waiting for a certain time, the skin is cleaned with an antiseptic substance and the application is made by injection method.

More than one filler can be used for the same person, depending on the depth of the collapsed area. Before the procedure, your doctor will tell you approximately what amount of filler is planned to be used. However, in some cases additional amounts may need to be used during or after the procedure. Especially in deep collapses, the effect may not be enough after the first application and additional applications may be required.

In filling applications, the effect can be seen immediately, the full effect may vary between 2 weeks and 3 months depending on the active substance used. After the application, a light massage and ice application can be made.

For reasons that are not fully understood, the permanence of fillers may be shorter than expected in some people. Therefore, no guarantee can be given regarding the results of the application.

Pain can be reduced by local anesthesic methods (cream, cold, etc.) applied before or during the procedure.

The method can be applied alone or in combination with other methods (laser, mesotherapy, PRP, etc.) that are thought to support this treatment.

Your photos will be taken in order to follow the progress of the medical procedure applied to you. Some of your photos can be used to support lectures at medical seminars and conferences. Some of your photos may also be used by your doctor for advertising purposes in order to show the effectiveness of the treatment as before and after the treatment pictures, without revealing your identity.

2- TREATMENT OBSTACLES OR RISKY SITUATIONS IN APPLICATION

It can be applied for the age range of 18-80 and the younger ages with parental approval. People with the following problems are not suitable candidates for the above mentioned application.

1) SLE (systemic lupus), porphyria, severe allergic reaction
2) Acute, chronic infections and sepsis
3) Known allergy to any of the substances to be applied
4) Infection at the application site
5) Presence of cancer or receiving chemotherapy treatments
6) Those who have a disease that suppresses the immune system or use drugs that suppress the immune system
7) Those with severe autoimmune disease, organ failure or systemic disease (such as diabetes, kidney failure, liver disease)
8) Abnormal platelet (trombocyt) dysfunctions (blood diseases; circulatory disorder, hypofibrinogenemia, critical thrombocytopenia)
9) Chronic liver disease
10) Anti-coagulant therapy
11) Pregnancy and breastfeeding period
12) Use of corticosteroids in the last 2 weeks before the procedure
13) Those with active psychological/psychiatric disorders

3- GENERAL RISKS AND UNDESIRED CONSEQUENCES (COMPLICATIONS)

Since injection is used in filling application, side effects such as pain and burning sensation at the injection site, bleeding, edema, bruising, irritation, short-term pinkness/redness of the skin, itching, nausea/vomiting, dizziness may occur due to any simple injection.

Infection, allergic reactions, abscesses or wounds with or without discharge, nodules (swelling), scars, palpable masses, asymmetry, discoloration, collapse are other side effects that may occur due to the procedure. Vascular occlusion, tissue loss, and organ loss, although rare, can be seen in the filling application area. Serious adverse events were reported very rarely in the clinical studies reviewed. In the case of serious effects, the duration of treatment may be prolonged or additional treatments may be needed.

In case of vascular occlusion, which may develop rarely during or after the application, your doctor may need to dissolve the filling partially or completely immediately in order to avoid a more serious complication. For fillings containing hyaluronic acid, in this case, a drug called hyaluronidase is used in the form of injections. Because of this possibility, you should also read and sign the attached "HYALURONIDAZ APPLICATION PATIENT INFORMATION AND CONSENT FORM" before you have your filling application done.

4- SUCCESS STATUS

The success of the treatment may vary from person to person, and adequate response may not be obtained as a result of the treatment. No guarantee can be given regarding the result of the procedure. There is no definite number of applications. For this reason, volume augmentation (dermal filler injection) treatment can be performed until the targeted result is achieved, and there is no limitation in this direction.

5- TRANSACTION AND TRANSACTION COST

If you give approval after reading this form, you will also give your consent "that you have been informed about the cost of the transaction before the transaction and you have approved the cost of the transaction to be made".

You have the right to choose the auxiliary personnel that will participate in the applications. If you notify us, the most appropriate personnel exchange will be provided.

The side effects that will occur will be evaluated by your doctor and the improvement (prescription, medical intervention, emergency response) procedures will be done by your doctor and health personnel.

6- ALTERNATIVE TREATMENTS

If you give your consent after reading this form, you will also give your consent that you have been informed in detail by your doctor about the treatments that may be an alternative to the treatment to be applied.

7- THINGS TO CONSIDER BEFORE APPLICATION

• At least three days in advance; ginko biloba, blood thinners, high-dose vitamin E, green tea, aspirin, food supplements, non-steroidal anti-inflammatory (rheumatic) and blood thinners should be discontinued.

• No peeling or irritating medicine or cosmetic product has been used on the area to be treated for the last 1 week.

• While coming to the application, you should come well rested.
• Alcoholic beverages must not be consumed in the 12 hours before the application

8- THINGS TO CONSIDER AFTER APPLICATION

• Do not touch the application area.
• Make-up application should be done after at least 24 hours.
• Do not massage the application area for at least 1 week.
• Take care not to overuse your mimics in the application area for at least 3 days.
• Avoid contact with water, soap, cosmetics and similar products, irritating rubbing and scratching until 48 hours after the procedure.
• Avoid intense sports for 1 week.
• Avoid hot and steamy environments such as saunas and jacuzzis for 1 week.
• If lip augmentation has been made, do not contact with a hot-cold substance for 2-3 days.
• If anesthesia is given in the application of lip augmentation, do not eat or drink anything until the sensation returns (2-3 hours).
• Protect the application area from the sun after the application.
• Use the treatment recommended by your doctor.
• If an unexpected effect develops, please consult your treating doctor.

9- BY SIGNING THIS FORM, YOU WILL AGREE ON FOLLOWING ITEMS :

• I received detailed information about the **Dermal Filling** injection procedure to be performed by the doctor ….... …….. regarding the diagnosis and treatment of my medical condition.
• I was informed about the benefits of the treatment, the method of application, the obstacles to the treatment and the situations in which the treatment would be risky, the general risks and possible undesirable results, the frequency of application, the success status, the cost, alternative treatments, and the things to be considered before and after the application.
• I was told that without my permission, any medical intervention or treatment cannot be applied on me unless it is necessary.
• I was told that any additional action other than those described in this form could be taken against my will to prevent serious harm to my health and to save my life.
• I was told that there may not be a definite success as a result of the procedure and that the success rate may vary from patient to patient and that no guarantee is given in this regard.

WRITE AND SIGN THE FOLLOWING STATEMENT IN THE BELOW FIELD BY YOUR HANDWRITING.

"I WAS INFORMED ABOUT THE TREATMENT AND PROCEDURES OF DERMAL FILLING. I HAVE READ, UNDERSTAND AND ACCEPT ALL THE CONDITIONS WITH MY FREE WILL EXPLAINED IN THIS FORM. I RECEIVED ONE COPY OF THIS FORM."

THIS FORM HAS BEEN ISSUED IN 2 COPIES. 1 COPY WAS DELIVERED TO THE PATIENT.

PATIENT

NAME AND SURNAME :

PASSPORT NO :

INFORMATION DATE : …./…./…. SIGNATURE:

WITNESS (IF POSSIBLE)

NAME AND SURNAME :

PASSPORT (OR CITIZENSHIP) NO :

TELEPHONE : SIGNATURE: