DR. EDA KİBAR DERMATOLOGY CLINIC

PATIENT INFORMATION AND INFORMATIVE CONSENT FORM

DATE : ……../…….. /……....

PROCESS INFORMATION

PROCESS NAME : FRACTIONAL LASER
REASON OF PLANNING THE PROCESS :

PATIENT INFORMATION

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

Dear Patient, PLEASE READ THIS FORM CAREFULLY

• The objective of this form is to enable your participation into the decision making process about your healthcare by informing you. This form has been designed in order to meet the needs of many patients under most conditions, nevertheless, it should not be considered as a document containing the risk of the entire applicable treatment. Based upon your individual healthcare, your doctor may provide you with different or additional information. After acquiring the advantages and possible risks of diagnosis, medical treatment and surgical interventions, it is up to your decision whether or not to accept these procedures. You are entitled to refuse to be informed except for the legal and medical necessities or withdraw your consent at any time.

• The purpose of this form is to inform you about the benefits, risks, undesirable results (complications) of the **Fractional Laser** 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.

• 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.

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. INFORMATION ABOUT THE PROCESSES TO BE DONE

Fractional laser treatment is a non-invasive treatment that uses a device to deliver a laser beam divided into thousands of microscopic treatment zones that target a fraction of the skin at a time, analogous to a photographic image being enhanced or altered pixel by pixel.

Fractional laser treatment has bridged the gap between the ablative and non-ablative laser techniques used to treat sun-damaged and ageing skin. While ablative laser treatments

work mainly on the epidermis (surface skin cells) and non-ablative treatments work solely on dermal collagen (mid-layer of skin) only, fractional laser treatment works at both the epidermal and dermal layers of the skin.

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. METHOD OF APPLICATION OF THE PROCEDURE

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

The frequency of application is between …. and …. weeks, the number of applications is …. It is planned to be between …. and …. sessions. However, the frequency and number of applications may change with your doctor's recommendation during your follow-ups.

- Usually 4-8 sessions are required.
- Treatments should be applied with 15-30 days intervals.
- It is usually a painful procedure.
- Topical anesthesia can usually be applied earlier.
- One month before treatment and one month after treatment, the patient should be away from sun and solarium.
- Treatment does not guarantee complete disappearance of existing complaints and the results can vary from one person to another.

3. 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) Acute, chronic infections and sepsis
2) SLE (systemic lupus), porphyria, severe allergic reaction
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

4. GENERAL RISKS AND UNDESIRED CONSEQUENCES (COMPLICATIONS)

Redness, swelling, pain may occur for 1-3 days after treatment; discoloration in the form of suntan, exfoliation may occur for 7-10 days. Staining, usually transient, which is called scar, though rarely, may occur on the skin after the procedure, these scars may very rarely remain.

Side effects such as pain and burning sensation at the injection site, bleeding, edema, bruising, irritation, short-term pink/redness of the skin, itching, nausea/vomiting, dizziness, which are not specific to mesotherapy and can develop due to any simple injection. effects may occur.

Side effects such as infection, allergic reaction, small abscess or wounds, nodules, scars, spotting, collapse are other side effects that may occur due to the procedure.

An adequate response may not be obtained from the treatment. Although no serious side effects were observed in the clinical studies reviewed, serious side effects were reported very rarely. In the case of serious effects, the duration of treatment may be prolonged or additional treatments may be needed.

5. 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 sessions. For this reason, mesotherapy treatment can be performed until the targeted cosmetic result is achieved, and there is no limitation in this direction.

6. APPLICATION AND APPLICATION 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 application and you have approved the cost of the application 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.

7. 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.

8. 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

9. 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.
- Moisturizing cream and sunscreen should not be neglected.
- After the procedure very hot bath, public bath, steam room, rubbing, washcloth should be avoided.
- For 1 month after the procedure peeling, peeling procedures, peeling creams should not be used.
- Concealer make-up should not be put on within 15 days after the procedure.

10. BY SIGNING THIS FORM, YOU WILL AGREE ON FOLLOWING ITEMS :

- I received detailed information about the **Fractional Laser** procedure for filling dissolution, which will be made 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.

Dr. Eda Kibar
Exclusive Dermatology & Aesthetic

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

"I WAS INFORMED ABOUT THE PROCEDURES AND APPLICATION OF FRACTIONAL LASER. 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: