OP. DR. AHMET CAYMAZ
KBB HASTALIKLARI, BAŞ & BOYUN CERRAHİSİ

Before and After Chemical Peeling Information Form

Before Treatment

• From tanning and direct sun exposure 2 weeks before each treatment.
color should be avoided.

- A sunscreen with SPF 30 or higher every day during the treatment period
Protective should be used.

Medicines containing high strength alpha-hydroxy acids (glycolic, lactic acid) or retinoids (Retin-A, Renova) should be discontinued 1-2 weeks before treatment.

AFTER TREATMENT:

Treated areas may feel tender, tight or dry for 3-5 days and may appear pink, red or slightly swollen.

-Pain rarely develops and can be treated with a pain reliever containing acetaminophen or a daily
How many times per hour, 15 minutes a cold compress is applied to improve.

- Treatment applied after chemical peeling and skin condition before treatment
The skin may peel to varying degrees (mild, barely visible or severe continuous peeling)
Peeling can continue for up to 2 weeks.

- In the first few days after treatment, excessive heat, excessive sweating, use of jacuzzi, steam bath, sauna or very hot shower should be avoided as it may cause bullae development and increase the risk of complications.

- Any post-procedure topical product should be used as described.

-Mineral make-up products can be applied after treatment if desired. Your makeup
It is preferable to apply it the day following the treatment.

- Avoiding direct sun exposure or solarium for 2-4 weeks after treatment and daily use of a broad-spectrum sunscreen with SPF 30 or above containing zinc or titanium should be recommended.

- Jacuzzi, swimming and other water activities should be avoided for 2 weeks
Electrolysis, facial wax and depilator use should be avoided for 2 weeks following the treatment.

Diagnosis _____

Treatment/procedure to be applied _____

Side/grade if applicable ☐ Right sided ☐ Left sided ☐ Both sided Grade _____

Should you not intend to be informed about the purpose, duration, advantages, success ratio, potential risks and complications and alternative options of the treatment to be applied and as well as about the subsequent potential risks in case you do not accept the treatment, please declare so below with your hand writing.

_____

I hereby declare that;

My attending physician informed me about my disease, the treatment option to be applied, its duration, advantages, success ratio, the fact that it does not necessarily guarantee the recovery of current status, period of healing, potential risks and complications, alternative techniques, the potential situations I will experience on the condition that I reject the treatment and compulsory performance of an additional operation/intervention/procedure if deemed necessary and s/he answered all my questions regarding these matters.

Above mentioned procedure has been disclosed to be performed on myself/patient I legally represent by the physicians, nurses as well as other healthcare professionals under the authority, surveillance and control of my attending physician.

I have been informed that if required, anesthesia will be performed by an anesthetist, sedation will be performed by an anesthetist or another physician competent in sedation and local anesthesia will be performed by my attending physician.

While being entitled to make decision and think straightly, I accept the medical procedure to be performed, and consent that my attending physician and his/her team will carry out any medical treatment option/surgical technique/intervention they deem to be necessary.

I authorize the hospital to examine, inspect, dispose of or keep the tissues or organs removed during the procedure for which I have consented above.

I allow my medical reports to be used for scientific researches provided that my identifying information is kept hidden.

Patient's Full Name: Date of Birth:	Signature:	Date:	Time:
Legal Representative's Full Name: Degree of Relationship: Reason why the consent is delivered by legal representative of the patient: ☐ Patient is not conscious ☐ Patient is under 18 ☐ Patient is not entitled to make decision ☐ Emergency	Signature:	Date:	Time:
Witness' Full Name:	Signature:	Date:	Time:
Informing Physician's Full Name:	Signature:	Date:	Time:
Interpreter's (If required) Full Name:	Signature:	Date:	Time:

Informed consent is delivered by the patient himself/herself if s/he is older than 18 years old, by the patient himself/herself together with his/her legal representative if the patient is aged between 15 and 18 and by the representative of the patient if the patient is under 15 years old and/or is unconscious and/or is not entitled to make decision and in case of emergency.