BOTOX APPLICATION INFORMED CONSENT FORM

The purpose of this form is to inform you about your health issues and to encourage you to participate in the decision to be taken. is to provide.
While this form has been defined to meet the needs of most patients in most circumstances, However, it should not be considered as a document that includes the risks of all treatment modalities. personal health

Depending on your situation, your doctor may give you different or additional information. The diagnosis will be made after learning the benefits and possible risks of medical treatment and surgical interventions.

It is up to you to accept or reject the applications. legal and medical obligation
You can refuse to be informed or withdraw consent at any time, except for certain circumstances.

Things to Know About Botox

The substance used in Botox application is secreted by the bacterium Clostridium botulinum. is a protein. This substance, by blocking the electrical transmission from nerves to muscles, temporarily reduces or destroys the function of the muscle in the area. Losing muscle function When it cannot contract, the wrinkles formed on the skin on it also decrease or disappear. During the Botox effect
these mimic muscles cannot be exercised. For this reason, facial expressions, especially expressions of astonishment and anger, Many expressions of joy and sadness are lost.
During this period, the skin has the opportunity to recover itself. finds.
Botox is not a miracle. The percentage will not change anything permanently. Also her face is 20 years It will not restore its previous appearance. Botox applications are only applied to certain areas of the face.
Provides temporary improvement in wrinkles.

Scope of application
Horizontal lines on the forehead
The lines between the two eyebrows that cause a frowning eyebrow appearance
Lifting the sides of both eyebrows
Lines on the sides of both eyes that show facial aging and
Wrinkles · Correction of lines on the lower eyelid and squint eyes
Lifting the tip of the nose
Appearance of the upper gingiva while smiling
Vertical lines (smoking lines or barcodes) on the upper and lower lip
lines) · Lifting the corners of the lips
The horizontal line between the lower lip and the chin
Making the chin skin smoother, orange peel appearance
correction · Clenching, grinding
Treatment of horizontal lines and vertical bands on the neck
Treatment of excessive sweating on the hands, feet, face and armpits

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:	Signature:	Date:	Time:
Date of Birth:			
Legal Representative's			
Full Name:	Signature:	Date:	Time:
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		
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.