OP. DR. AHMET CAYMAZ
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Chemical Peeling and Dermabrasion Consent Form

This consent form is used for microdermabrasion, chemical peeling and topical skin care products.
With skin care treatments that include its use and are not limited to these applications only.
Information needed to assist patients in making the relevant informed consent decision contains.

Microdermabrasion is a mechanical method that removes abrasive elements such as diamond-tipped pads.
It is used to remove the outermost layer of the skin through its use. Chemical so-repellants protect the upper layers of the skin from acids such as glycolic, lactic, salicylic and trichloroacetic acid.
removed by use.

Alternative treatments to microdermabrasion and chemical peels are laser skin resurfacing. cing, dermabrasion, plastic surgery or no treatment
it could be.

Possible risks, side effects and complications related to skin care treatments are listed below and are not limited to these.

- Prolonged erythema (redness) and erythema

-Allergic reactions

-Bullous development

- Visible flaking/peeling

- Darkening or lightening of skin color

-Abrasion (superficial incision) or temporary lines and lines can be formed with microdermabrasion.

-Activation of recurrent viral infections such as acne breakout or herpes simplex
It can evolve.

-Infection and scarring

The risk of complications is higher in the presence of darker skin type. On this procedure-pregnancy, recent facial surgery, allergies,
susceptibility to cold burns, hot blisters, and/or topical and/or oral medication use
I also disclosed the necessary information.

I understand that it is not possible to predict the development of the side effects and complications described above and the results cannot be guaranteed. I have read all of this consent form and understood the information presented to me on the procedure to be done. I am satisfied with all my questions and concerns about this issue.

Patient Name and Surname:

Patient signature :

History :

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.