PATIENT INFORMATION AND CONSENT FORM

NAME OF THE PROCESS: FILLER APPLICATION
INFORMATION DATE:
NAME SURNAME:
DATE OF BIRTH:

This form covers the application of intradermal fillers (hyaluronic acid or similar products) and their possible risks and risks. It is intended to inform about the complications (undesirable results). Please read the form carefully. If you have questions or points that you do not understand, please ask your doctor for help.
Fillers are used to increase the volume of any structure in the body (face, back of the hand, nose, etc.), to reduce deep wrinkles. It is used to fill and plump the lips. Permanence of fillers, depending on the product used varies, with an average of 4-12 months. Available in fillers containing longer-lasting synthetic material.
Before the procedure, anesthetic agent is applied by cream or injection method. a certain time
After waiting, the skin is cleaned with an antiseptic substance and the application is made by injection method. same More than one filling material can be used depending on the person and the depth of the collapsed area. Light massage after application
and ice is applied. In deep collapses, it is more successful when it is done again within 2 months after the first application. results are obtained.
For reasons that are not fully understood, the permanence of fillers in some people is longer than expected. gets short. Therefore, no guarantee can be given regarding the results of the application. It is possible to take photographs or video images during the application and that they are used in educational and scientific studies.
I understand and accept that it can be used. (Please delete the sentence if you don't want it.)

Are you at risk of pregnancy?
Yes No
Do you have infection in the application area?
Yes No
Are you breastfeeding?
Yes No
Are you using cortisone?
Yes No
Do you have diabetes?
Yes No
Are you using any other medication?
Yes No
Do you have a tendency to bleed?
Yes No
Do you have allergies?
Yes No
Do you have a systemic infectious disease?
yes no
Do you have an autoimmune disease?
Yes No
Aspirin or blood thinners before application
Have you used?
Yes No
Do you have herpes attacks?
Yes No
Any cosmetic product to the application area
did you drive
Yes No
Have you had a filler application before? If yes, allergy
Or did you encounter an unexpected event?
Yes No
Do you have HBsAg, HCV or HIV positivity?
Yes No
Do you have Active Skin disease?
Yes No

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.