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

INFORMATION AFTER MESOTHERAPY PROCESS:

-After the application, the area should not be touched.

- Do not take a bath for 24 hours after the application.

The application area should be protected especially with sunscreen creams.

- Cold compresses can be applied to the face with a cold gel pack wrapped in a towel for 15 minutes every 2 hours. Cold compress application should be continued for the first 24 hours.

Despite all these precautions, bruising may occur on the face; but this bruise will disappear.

- If the physician deems it appropriate, various creams and oral medications can be used for the treatment of edema, redness and bruising on the face. No cream should be applied to the face and oral medication should not be used without consulting a physician.

It is important to inform your doctor if an unexpected effect is observed.

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:	Signature:	Date:	Time:
Reason why the consent is delivered by legal representative of the patient: ☐ Patient is not conscious ☐ Patient is not entitled to make decision	☐ Patient is under 18 ☐ 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.