

Dermal Filler Treatment

Hyaluronic Acid and Similar Fillers

INFORMED CONSENT FORM

Patient's Full Name	ID / Passport No
Date of Birth	Date / Time of Information

Dear Patient,

The purpose of this form is to inform you about matters concerning your health so that you can take part in the decision to be made. Please read the form carefully and ask your physician about anything that is unclear before signing.

This form has been prepared to meet the needs of most patients in most circumstances; however, it should not be regarded as a document that covers every risk of every form of treatment. Depending on your personal health, your physician may give you different or additional information.

After learning about the benefits and possible risks of the diagnosis, medical treatment and surgical procedures, it is your decision whether or not to accept the procedure. Except where legally or medically required, you may decline the information or withdraw your consent at any time.

Information About the Procedure

Fillers are used to add volume to areas such as the face, the back of the hands and the nose, to fill deep wrinkles and to enhance the lips. Duration varies with the product and the individual; for hyaluronic acid fillers it is on average 4-12 months. In some people, for reasons not fully understood, the effect may be shorter than expected; therefore no guarantee can be given regarding the result.

A numbing cream or local anaesthetic is applied before treatment. After the skin is cleaned with an antiseptic, the filler is injected. More than one product may be used depending on the depth of the hollow area. Gentle massage and cold may be applied afterwards. For deep hollows, an additional session may be planned within a few months of the first, on your physician's advice.

Before Treatment

- Come to your appointment well rested; do not drink alcohol beforehand.
- At least three days before, and after consulting your physician, stop ginkgo biloba, blood-thinning medicines, high-dose vitamin E, green tea, aspirin and anti-rheumatic medicines.

After Treatment

- Do not touch the treated area; wait at least 24 hours before applying make-up.
- Do not massage the area for at least a week (unless your physician specifically advises it).
- Try not to use facial expressions in the treated area excessively for at least 3 days.
- Avoid strenuous exercise and hot environments such as saunas and jacuzzis for one week.
- After lip filler, avoid very hot or cold food and drink for 2-3 days; if an anaesthetic was used, do not eat or

drink until sensation returns (2-3 hours).

Possible Side Effects

- Redness, pain, tenderness, swelling, bruising and itching
- Infection and flare-up of cold sores
- Allergic reactions, delayed swelling or swelling with discharge
- Palpable lumps, asymmetry, discolouration and depressions
- **Vascular occlusion:** A rare but serious complication. If you notice marked paleness or purplish discolouration of the skin, severe pain or any visual disturbance during or after treatment, contact your physician immediately. Prompt treatment is required.

If an unexpected effect occurs, please contact the physician who performed the treatment. Any side effects will be assessed by your physician and the necessary treatment planned.

How to Reach Us When Needed

If you experience unexpected pain, increasing swelling, fever, bleeding or anything that concerns you after the procedure, contact us on +90 542 338 86 61 or +90 542 255 52 86. In an emergency, go to the nearest healthcare facility. If you change your mind after declining the procedure, you may apply again at any time.

What Your Physician Needs to Know About You

For your safety, please answer the questions below. If you are unsure about a question, you can complete it with your physician.

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| 1. Could you be pregnant? | ☐ Yes ☐ No |
| 2. Are you breastfeeding? | ☐ Yes ☐ No |
| 3. Is there an infection or active skin disease in the treatment area? | ☐ Yes ☐ No |
| 4. Do you have diabetes? | ☐ Yes ☐ No |
| 5. Do you take cortisone or any other medicine regularly? | ☐ Yes ☐ No |
| 6. Do you have any allergies? | ☐ Yes ☐ No |
| 7. Do you have a tendency to bleed? | ☐ Yes ☐ No |
| 8. Have you recently taken aspirin or a blood-thinning medicine? | ☐ Yes ☐ No |
| 9. Do you have a systemic infectious disease? | ☐ Yes ☐ No |
| 10. Do you have an autoimmune disease? | ☐ Yes ☐ No |
| 11. Do you get frequent cold sores? | ☐ Yes ☐ No |
| 12. Have you applied any cosmetic product to the treatment area in the last 24 hours? | ☐ Yes ☐ No |
| 13. Have you had filler or a similar treatment in this area before? If so, did anything unexpected happen? | ☐ Yes ☐ No |
| 14. Are you HBsAg, HCV or HIV positive? | ☐ Yes ☐ No |

Notes / medicines used:

Patient / Legal Representative Consent Statement

Diagnosis

Treatment / procedure to be performed

If you do not wish to be informed about the purpose, duration, benefits, chance of success, recovery process, possible risks and complications, alternative methods of the treatment and the situations you may face if you decline it, please state this below in your own handwriting.

- My physician has informed me about my illness/condition and explained what the procedure is, its purpose, duration, benefits, chance of success, that there is no guarantee that my current condition will improve, the recovery process, possible risks and complications, alternative methods and the situations I may face if I decline the procedure. All my questions on these matters have been answered in a way I can understand.
- It has been explained to me that the procedure described above will be performed on me/on the patient I legally represent by physicians, nurses and other healthcare staff under the authority, supervision and direction of my physician.
- I understand that there is no guarantee that the procedure will improve my current condition, that there is no certainty in medicine and surgery, and that results may vary from person to person.
- I know that I am not obliged to give consent if I do not wish to, and that I may withdraw my consent before the procedure begins.
- Provided that my identity is kept confidential, I consent to my medical records and before/after photographs being used for medical follow-up, scientific and educational purposes. (If you do not consent, please cross out this statement.)
- Being of sound mind and capable of making decisions, I freely consent to the medical procedure described above being performed by my physician and their team.

Signatures

I declare that I have read and understood all pages of this form and accept the statements above. Please write **"I have read, understood and agree."** in your own handwriting:

Patient			
Full Name	Signature	Date	Time
Patient's Legal Representative (if applicable)			
Full Name / Relationship	Signature	Date	Time
Reason consent is obtained from the legal representative: ☐ Unconscious ☐ Under 18 ☐ Lacks capacity ☐ Emergency			
Witness			
Full Name	Signature	Date	Time
Informing Physician			
Full Name Op. Dr. Ayşe Öznur Akidil	Signature / Stamp	Date	Time
Interpreter (if required)			
Full Name	Signature	Date	Time

Consent is obtained from the patient if over 18; from both the patient and the legal representative for patients aged 15-18; and from the legal representative for unconscious patients, patients under 15, patients lacking decision-making capacity and in medical emergencies. Information is provided in accordance with the Turkish Patient Rights Regulation (Official Gazette of 01.08.1998, No. 23420). This is the English version of the Turkish consent form; in case of discrepancy, the information given verbally by your physician prevails.

Prepared with reference to patient information documents of medical societies, primarily the Turkish Society of Plastic Reconstructive and Aesthetic Surgery.