

Chemical Peel

Chemical Skin Peeling and Skin Treatments

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

Chemical peels and other skin treatments have been used for many years to treat various skin problems. Sun spots, fine wrinkles and uneven pigmentation can be treated with these methods. There are many methods and products acting at different depths; in some cases a chemical peel may be combined with other procedures. A chemical peel is not a substitute for surgery to tighten sagging skin.

Possible Risks

Although most patients do not experience complications, you should discuss each possible risk with your physician.

- **Infection:** Rare; may be bacterial or viral. In people with a history of cold sores, they may recur after the procedure; medicine may be recommended beforehand to prevent this. Any infection requires treatment.
- **Scarring:** Normal healing is expected, but abnormal scars and, rarely, keloids may develop; further treatment may be needed.
- **Pigment changes:** Permanent lightening or darkening of the skin may occur. A line of demarcation may form between treated and untreated skin. Redness may persist for a long time.
- **Unsatisfactory result:** An undesired appearance, crusting and permanent discolouration may occur.
- **Recurrence of lesions:** Treated skin problems may recur; further treatment may be needed.
- **Skin cancer and skin diseases:** A peel does not protect against skin diseases that may develop in the future.
- **Allergic reactions:** Rare reactions to the products or medicines used.
- **Sun sensitivity:** Some agents make the skin sensitive to the sun and may reduce its ability to tan. Regular sunscreen use is required after the procedure.

- **Duration of results:** A chemical peel does not prevent new wrinkles and does not stop skin ageing; regular skin care may be needed.
- **Delayed healing:** Healing may take longer than expected; healing skin is thin and easily damaged.
- **Heart rhythm disturbance:** Deep peeling agents have been reported to cause heart rhythm disturbances; if this occurs during the procedure, treatment is required.
- **Anaesthesia:** Local or general anaesthesia used in deep peels has its own risks.

Need for Further Treatment

Although complications are rare, further treatment or surgery may be needed if they develop.

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.