INFORMED CONSENT FORM

RF Microneedling (Gold Needle)

DRAFT: Not valid for clinical use before product verification, individualized planning and clinician counseling.

PATIENT DETAILS

Hasta adı soyadı / Patient full name: _____

Doğum tarihi / Date of birth: _____

Hasta dosya no / Patient file no: _____

Tarih ve saat / Date and time: _____

Klinik / Facility: _____

Procedure and method

RF microneedling combines controlled needle penetration with radiofrequency energy targeted to skin layers. Device, depth, energy settings, treatment area, number of sessions and anesthesia are individualized.

Potential risks and complications

Pain, redness, swelling, crusting, hyper- or hypopigmentation, burns, blisters, infection, scars, acne/herpes flare and unintended fat loss or contour depression may occur. Extra precautions apply near eyes; assess pacemakers and electronic implants.

Alternatives

No treatment; discuss superficial skin care, laser/other energy-based procedures or other indicated methods.

Aftercare and emergency signs

Follow sun protection and skin-care instructions. Contact the clinic for extensive blistering, spreading redness, fever or worsening pain.

Mandatory procedure-specific verification

Device make/model, disposable tip, settings/depth, area, skin phototype, active infection, herpes history, metal/electronic implants.

CLINICIAN MUST COMPLETE BEFORE TREATMENT

Exact product/device, manufacturer, batch and authorization: _____

Ingredients / concentration / dose / volume and route: _____

Anatomical sites, treatment plan and sessions: _____

Patient-specific risks, allergies and relevant conditions: _____

Procedure-specific emergency response and follow-up: _____

General safety information

Disclose medical history, allergies, infection, herpes, abnormal scarring, immune conditions, bleeding risks, medications, pregnancy/breastfeeding and previous aesthetic procedures. Do not discontinue prescribed medicines without medical advice.

Expectations, further sessions and emergencies

Results vary and symmetry, a specific outcome or durability cannot be guaranteed. Extra sessions, correction or treatment may be required and their benefits, risks and costs should be discussed separately. Severe allergy, breathing difficulty, vision change or unexpected intense pain needs urgent assessment.

Counseling and privacy

This document does not replace clinical examination and verbal counseling. Clinical photos are sensitive health information. Consent for advertising or social media use is separate and is NOT granted here.

PATIENT DECISION AND SIGNATURES

The actual planned treatment/product/device, potential benefits, uncertainties, material risks, alternatives and my right to decline have been explained in a language I understand. My questions were answered. I understand that outcomes are not guaranteed and that I may withdraw consent before treatment.

[ ] I consent [ ] I decline / defer

Patient printed name and signature: _____

Counseling physician: Op. Dr. Mert Sandıkcı / signature: _____

Legal representative if required / signature: _____

Interpreter and language if required / signature: _____

Signature date and time: _____

DRAFT • Not a final patient consent form until reviewed by the treating physician and legal counsel.