INFORMED CONSENT FORM

Dermal Filler Injections

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

Material is injected beneath the skin in selected facial/body sites to modify volume, contour or lines. Record the exact material (e.g., hyaluronic acid), manufacturer, volume, sites and technique. Not all fillers can be dissolved; duration varies by product and patient.

Potential risks and complications

Pain, bruising, swelling, asymmetry, lumps, migration, infection, allergy and delayed inflammatory nodules may occur. Accidental intravascular injection or vessel compression can cause vascular occlusion, skin necrosis and, rarely, permanent blindness or stroke. Severe allergic reactions are possible.

Alternatives

No treatment; discuss other appropriately authorized products or non-injectable treatments with different and often limited effects. Reversal or correction is not always feasible.

Aftercare and emergency signs

Seek emergency attention for sudden intense pain, blanching or mottled purple skin, cold skin, changes in vision or stroke-like symptoms. Discuss restrictions on pressure, massage, exercise and further treatment.

Mandatory procedure-specific verification

Product name, ingredients, batch/lot, expiry, authorization, total volume (mL), injection sites, vascular emergency plan and whether hyaluronidase is appropriate.

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.