INFORMED CONSENT FORM

Platelet-Rich Plasma (PRP)

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

Blood is collected from the patient and processed to concentrate platelets for application to a specified area. Record the volume collected, preparation system, target site and route. Benefit is variable and not assured.

Potential risks and complications

Blood collection may cause bruising, fainting and pain. Injection may cause infection, bleeding, tissue injury, swelling or nerve/vessel damage. Poor preparation or sterility may introduce contamination. Platelet/bleeding disorders and anticoagulants require assessment.

Alternatives

Decline treatment; discuss alternative evidence-based treatment or observation based on the underlying concern.

Aftercare and emergency signs

Follow site-care instructions; seek assessment for fever, spreading redness, marked swelling or severe pain.

Mandatory procedure-specific verification

Blood draw volume, PRP kit/system and lot, any activator, treatment site, platelet disorders, infection and bleeding risk.

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.