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

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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.

INFORMED CONSENT FORM

Wrinkle Treatment (Botulinum Toxin / Specify Method)

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

Wrinkle treatment depends on the chosen method. When botulinum toxin is selected, small injections temporarily reduce activity in targeted facial muscles. Record brand, total units, treatment sites and authorization status. Other methods may require distinct consent.

Potential risks and complications

Bruising, pain, headache, asymmetry, insufficient or excessive effect, eyebrow/eyelid droop, double vision and dry eye can occur. Rarely, spread of toxin effect may cause difficulty swallowing, speaking or breathing and requires emergency care. Neuromuscular illness and certain drugs may change risk.

Alternatives

Decline treatment or consider other options (e.g., fillers, laser or skin therapies) for different indications. Effects are temporary and repeat treatments may be needed.

Aftercare and emergency signs

Seek emergency care for swallowing or breathing difficulties. Follow individualized guidance on pressure, massage, exercise and cosmetic procedures.

Mandatory procedure-specific verification

Exact technique, toxin brand and units, injection sites, pregnancy/breastfeeding, neuromuscular conditions, prior reactions and interacting medications.

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

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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.

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.

INFORMED CONSENT FORM

Exosome-Based Treatment – Product/Regulatory Verification Required

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

“Exosome” may refer to materially different products and origins. Topical cosmetic use, use after microneedling and injection are different routes. This form is NOT authorization to proceed unless provenance, composition, legal classification, authorization and route are verified. Clinical effectiveness and long-term safety evidence may be limited.

Potential risks and complications

Depending on product and route, risks may include allergy, redness, infection, contamination, inflammation, unexpected immune responses and unknown delayed/long-term harms. Legal eligibility of injection or other invasive use must be separately established. Skin rejuvenation claims cannot be guaranteed.

Alternatives

Decline the product; discuss skin care and alternatives with better-established evidence where appropriate.

Aftercare and emergency signs

Seek prompt care for fever, increasing inflammation, pus, rash or respiratory symptoms. Establish follow-up and adverse-event reporting.

Mandatory procedure-specific verification

MANDATORY: Verify complete product/manufacturer, human/animal/plant origin, ingredients, Turkish regulatory classification/authorization, intended route, sterility, lot and indication before proceeding.

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

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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.

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

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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.

INFORMED CONSENT FORM

Skin Booster / “Youth Injection” – Identify Product

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

“Youth injection” is a marketing category, not one standardized medicinal product. It may refer to injected hyaluronic acid, vitamins/peptides or other compositions. The clinician must document the exact formulation, intended route, authorized indication and injection plan.

Potential risks and complications

Pain, bruising, swelling, infection, allergy, papules/nodules, unevenness, delayed inflammation or discoloration may occur. Depending on product and anatomy, vascular injection can cause occlusion and tissue necrosis; facial injections rarely may cause visual loss.

Alternatives

No procedure; discuss skin care or other treatment options based on the actual formulation and indication.

Aftercare and emergency signs

Seek urgent help for disproportionate pain, blanching/mottling, vision changes or severe allergy. Follow aftercare advice.

Mandatory procedure-specific verification

Exact brand, manufacturer/composition/lot, route, depth, volume, indication and vascular emergency plan.

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

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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.

INFORMED CONSENT FORM

Salmon DNA (Polynucleotide / PDRN – Verify Product)

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

“Salmon DNA” covers products with potentially different polynucleotide/PDRN ingredients and origins. The clinician must explain the actual composition, animal source, sterility and legal authorization for the intended route. Cosmetic improvement is not guaranteed.

Potential risks and complications

Pain, swelling, bruising, infection, allergy/hypersensitivity, papules, nodules, inflammation and technique-related tissue damage can occur. Ask specifically about fish or ingredient allergy. Long-term safety evidence varies by formulation and indication.

Alternatives

Decline treatment; discuss other specified products, topical skin care or better-established options.

Aftercare and emergency signs

Seek urgent care for severe rash, swelling of face/tongue, difficulty breathing or worsening signs of infection.

Mandatory procedure-specific verification

Full product name, PN vs PDRN, source/protein residues, allergy history, authorization, lot and injection route/volume.

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

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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.

INFORMED CONSENT FORM

Injectable Skin Hydration / Hydrating Skin Booster

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

“Hydrating skin booster” can refer to different hyaluronic-acid formulations and other mixtures intended to improve skin hydration appearance. Specify actual product class, concentration, depth, total volume and authorization.

Potential risks and complications

Bruising, edema, pain, itching, raised bumps, allergy, nodules, infection and uneven appearance may occur. Depending on material and anatomy, vascular occlusion, tissue injury and rare visual complications are possible. Repeat sessions may be required.

Alternatives

No treatment; appropriate topical moisturizers or alternative skin procedures.

Aftercare and emergency signs

Seek urgent assessment for progressive bruising or blanching, severe pain, vision changes, widespread reaction or signs of infection.

Mandatory procedure-specific verification

Product/ingredients and lot, HA crosslinking status, site/depth/volume, allergies and emergency plan.

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

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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.

INFORMED CONSENT FORM

“Paris Glow” / Branded Mesotherapy Protocol

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

“Paris Glow” is not a standardized procedure or formulation; it may denote a proprietary mesotherapy/injection protocol. The exact products, doses and injection depths must be disclosed beforehand. A different formulation requires renewed risk assessment and consent.

Potential risks and complications

Injection pain, bruising, swelling, allergy, infection, pigmentation, granuloma/nodules, uneven appearance or insufficient effect may occur. Depending on formulation and anatomy, vascular injury/occlusion and tissue loss may be serious risks.

Alternatives

Decline treatment; discuss topical skin care or alternatives with clearly identified ingredients.

Aftercare and emergency signs

Seek immediate assessment for increasing pain, color change, fever, infection or any visual symptoms.

Mandatory procedure-specific verification

Every component brand/ingredient/dose/lot, administration depth, authorization documents and component allergies.

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

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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.

INFORMED CONSENT FORM

“Lifting Injection” (Specify Formulation and Method)

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

“Lifting injection” is not a standardized medical product name; it may describe biostimulators, fillers or mesotherapy mixtures marketed for tightening or lifting. This form does not authorize use before exact product and method are documented.

Potential risks and complications

Pain, swelling, bruising, asymmetry, allergy, irregularities, infection, nodules/granulomas, persistent firmness and unsatisfactory results may occur. Injectable fillers/biostimulators may carry vascular complications and tissue necrosis; not all materials are reversible.

Alternatives

No treatment; once the actual product class is known, discuss skin care, energy-based or other appropriate treatments.

Aftercare and emergency signs

Get emergency care for severe pain, mottled/blanched skin, sudden visual symptoms or serious allergy.

Mandatory procedure-specific verification

Actual product/class, authorized indication, formula, lot, route, volume, sites, reversibility and complication plan.

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

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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.