

## PATIENT INFORMATION AND CONSENT FORM

NAME OF THE TRANSACTION	<b>MESOTHERAPY</b>
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NAME SURNAME		AGE		GENDER	
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INFORMATION DATE		HOUR	
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This form provides information about mesotherapy application and its possible risks and complications (undesirable consequences). is aimed at. Please read the form carefully. If you have questions or do not understand anything, please ask your doctor for help. please ask.

Mesotherapy is the application of special drug mixtures prepared for different purposes into the middle layer of the skin using special needle tips. It is a special injection method applied using Mesotherapy to renew, moisturize and revitalize the skin. It can be applied to the face, neck and décolleté area. It is applied to the scalp to revitalize hair in case of hair loss. applicable. It can be applied to the arms, abdomen and legs for regional slimming and cellulite treatment. In mesotherapy The products used are hyaluronic acid, vitamins, proteins and minerals. Mesotherapy method provides skin elasticity. It works by renewing fibers, regulating subcutaneous circulation and reducing subcutaneous fat tissue. Mesotherapy is performed in sessions at certain intervals. Since there may be pain during application, local Anesthetic creams can be used. To get good results from the treatment, sessions must be held regularly. During the application, photographs or video images can be taken and these can be used in educational and scientific studies. I understand and accept that it can be used **(please cross out the sentence if you do not want it).**

**PLEASE ANSWER**

	YES	NO		YES	NO
Are you at risk of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	You have an infection at the application site ?	<input type="checkbox"/>	<input type="checkbox"/>
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use medication?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Anything related to muscles and nerves Do you have a disease?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery in the underarm area?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a systemic infection?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have migraine attacks?	<input type="checkbox"/>	<input type="checkbox"/>
Did you use aspirin or blood thinners before the application?	<input type="checkbox"/>	<input type="checkbox"/>	Previous botulinum toxin application allergy or an unexpected event during Have you encountered?	<input type="checkbox"/>	<input type="checkbox"/>
Have you applied any cosmetic products to the application area?	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotic (aminoglycoside) or muscle Do you use relaxant medication?	<input type="checkbox"/>	<input type="checkbox"/>
Are you HBsAg, HCV, HIV positive?	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Name and Surname (*)	Witness Name and Surname (**)	Responsible Doctor
signature	signature	signature

(\*) If the patient is a minor, it is signed by the legal guardian.

(\*\*) The patient was awake and conscious and signed the form in my presence.

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### SIDE EFFECTS THAT MAY OCCUR AFTER MESOTHERAPY APPLICATION

- Redness, bleeding
- bruise
- Infection
- allergic reactions
- Burning, itching
- Edema

### ISSUES TO BE CONSIDERED BEFORE APPLICATION

- Please come well rested when coming to the application.
- Do not consume alcoholic beverages before the application.
- At least three days in advance; ginko biloba, blood thinners, green tea, aspirin and non-steroidal anti-inflammatory drugs

Inflammatory (rheumatic) medications should be discontinued.

### ISSUES TO BE CONSIDERED AFTER APPLICATION

- Avoid contact with the application area.
- Do not take a bath for one day after the application.
- Protection from the sun on the application day
- Using creams recommended by your doctor after the application
- If any unexpected effects occur, please consult your doctor.

Information about you (identity, illness, treatment received) without your consent and court order will not be disclosed. You have the right to view and make a copy of your own file, but this right does not include the right to look at individuals' files. Any side effects that may occur will be evaluated by the doctors of our center. and improvement (prescription regulation, medical intervention, emergency intervention) procedures are carried out by our doctor and healthcare staff. It will be done by. You have the right to choose the auxiliary health personnel who will participate in the practices. To us If you notify us, the most appropriate personnel replacement will be provided.

The ability to apply other medical treatment methods other than mesotherapy is completely at my discretion, and my doctor cannot restrict me in this regard. An explanation was given for me to continue my primary treatment. I was told that I should inform my other doctor about mesotherapy treatment. I know that I have the right to opt out at any stage of treatment if I wish. My epiphany came before the mesotherapy treatment. Between my clarification and declaration of consent, I had enough time to think and do the necessary research.

By signing where my name is written below, I declare that I have read this information and consent form, my doctors I was informed verbally and in writing about the procedures to be performed by me in a language I can understand, and that all that my questions have been answered and that I have obtained all the information I need (*Patient Rights Regulation, Official Newspaper, Date: 01.08.1998; Number: 23420*), I give my free and clear will permission to my doctors to perform **Mesotherapy** . I declare that I have given it.

Name and surname :

Signature, Date :

Doctor Name :

Signature, Date :

Supporting Personnel\* :

\*\*\*\* Supporting Personnel: Nurses and estheticians who work in our center and have received the necessary certificates and training.

Patient Name and Surname (*)	Witness Name and Surname (**)	Responsible Doctor
signature	signature	signature

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