



## RENUVION UYGULAMA İNGİLİZCE BİLGİLENDİRİLMİŞ ONAM FORMU



Dokuman No:YÖN.RB.234-01 | Yayın Tarihi:04.03.2020 | Rev.No:00 | Rev.Tarihi: | Sayfa No:2/1

### RENUVION COSMETIC TECHNOLOGY INFORMED CONSENT FORM

#### GENERAL INFORMATION ABOUT THE PROCESS

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for surgery as proposed by your plastic surgeon and agreed upon by you. The treatment will use a helium plasma device to deliver radiofrequency energy resulting in heat to the subdermal connective tissues for therapeutic purposes.

My procedure has been fully explained to me. I understand that the practice of medicine and surgery is not an exact science and that results may vary. While there may be some initial improvement, the full clinical results may not be apparent for approximately six to twelve months and no guarantees of my results have been given to me.

#### Experiences and/or risks associated with the use of Renuvion may include:

- Although uncommon, I understand the following are possible experiences and/or risks of this procedure: unintended burns, infection of incision sites, gas buildup resulting in temporary and transient crepitus or pain, or temporary nerve injury.
- I understand that local infiltration anaesthesia will be used and the advantages and disadvantages of additional sedation have been explained to me.
- I may experience mild to moderate swelling post procedure that can potentially last a few days to a few weeks.
- I understand that I may experience temporary discomfort during and post procedure.
- It has been explained to me that there may be additional risks associated with the use of other products, technologies or procedures in conjunction with Renuvion.
- I understand the importance of following the pre/post procedure instructions given to me by my provider and that failure to comply with all instructions may result in an unsatisfactory result and/or increase my risk of complications.
- I understand that while the manufacturer does not list any declared contraindications for this procedure, my physician has reviewed my health history and advised me of any "cautions or warnings" that may be associated with radiofrequency energy based on my medical history.
- I consent to having clinical photographs and /or video taken before, during and after my procedure. I understand that these are an important part of my medical record. In addition, I consent to the use of these photographs and/ or videos for clinical and medical educational purposes.
- The procedure, risks, ramifications, complications and alternative methods of treatment have fully been explained to me by my provider(s) and I have been given the opportunity to have my questions answered. My signature below acknowledges that I have been fully informed and that I consent to the procedure listed on page one.

**Estimated Time of Procedure:** ..... - ..... minutes

#### Critical Lifestyle Recommendations regarding the Patient's Health:

After the procedure, I received information about what I should do/change regarding my lifestyle (Diet, bath, drug use, movement status and / or restraint status).

#### How to Reach Medical Help on the Same Subject:

I received information on how to get medical help (From my own physician, a different physician, the hospital treatment and 112 in case of emergency).



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**Contact Phone Numbers:** Hospital Phone: +90 212 274 69 25 - 444 25 93

You can ask your doctor for more detailed information about the procedures.

### Informed Consent:

I have read this information and consent to this form by signing the place where my name is written below. I declare that I allow my doctor to perform the Fillers Application process with free and open will.

Please; in your own handwritten statement that you have understood what you have been told and read about the side effects and all possible risks that may occur during and after the procedure:

.....  
.....

I authorize Dr..... or designated person(s) to perform the proposed procedure listed below utilizing the Renuvion® technology.

Tarih:...../...../..... Saat:

IF THE PATIENT'S CONSCIOUS	IF THE PATIENT'S UNCONSCIOUS AND ACCOMPANIED BY HIS/HER LEGAL REPRESENTATIVE
<b>Patient's</b> Name Surname :..... Address :..... Phone :..... Signature : .....	<b>legal representatives* or guardians</b> Name Surname :..... Address :..... Phone :..... Signature : .....
<b>Doctor</b> Name Surname:..... Signature:.....	<b>Doctor</b> Name Surname:..... Signature:.....
<b>Witness **::</b> Name Surname:..... Signature: .....	<b>Witness **::</b> Name Surname:..... Signature: .....