**PATIENT**

**ID/ DOB**

Procedure

Site

Indication/benefit

Specific risks:

This consent form outlines the risks, benefits, alternatives as well as complications that could occur with the injection of hyaluronic acid fillers. It complements your consultation. These products are injected to temporarily improve lines, wrinkles and folds in the face and periorbital area, to sculpt lips and form facial contours. This material serves as a supplement to the consultation, regarding the options available to you and the risks, benefits their implications, in your particular circumstances. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, please ask before signing. I understand that this treatment is part of a medical condition affecting my quality of life, thus requiring treatment. The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above.

RISKS

Possible side effects and complications include but are not limited to: Bruising, Redness, Swelling, Pain at injection site, tenderness, Itching, allergic reaction, raised bumps or lumps or palpable bumps under the skin, reactivation of herpes or viral infections, bacterial infection, abscess, arterial and or venous clotting (thrombus), and rarely, the risk of permanent damage to skin, including skin and soft tissue necrosis, blindnes, cerebral ischemia, and stroke. I have also been informed of the risks involved when injecting areas with underlying sensitive structures (i.e., nerves, vessels and eyes). Rare but documented risks include blindnes, stroke, skin necrosis and loss of tissue requiring reconsturction. In very rare cases, prolonged induration, suppuration (pussing out) and greyish discoloration at the treatment location have developed within weeks or months after treatment and last several months. I declare that I am not allergic to dermal filler or to lidocaine local anaesthetic, nor any of the excipients.

OUTCOMES

I agree that no guarantee express or implied is given that results will match my expectations and desired outcomes.

Further treatment, retreatment or touchups will be provided at an appropriate separate charge.

*If you are pregnant, nursing or have an infection or a history of abnormal scarring or autoimmune disease, this may not be the treatment for you. If you are taking immunosuppressant’s or blood thinners or you have a history of oral herpes simplex, please inform your Surgeon.*

*If you suffer or have suffered* ***from dysmorphia or ANY other psychiatric psychological diagnosis or conditions*** *you MUST declare these BEFORE undergoing treatment.*

I undertake treatment in good faith and as a patient I understand that these protocols may involve highly specialist procedures which may cause irreparable damage to others when used by inappropriately trained and or inexperienced and or unqualified others. I the undersigned undertake not to provide or cause to be provided such treatment to others unless appropriately trained and licensed. In such circumstances, I undertake full and unlimited liability for the consequences of such actions, including vicarious liability, third party liability, loss of reputation and loss of business.

An individual's choice to undergo a procedure is based on the comparison of risk to potential benefits. I declare that all therapeutic options including reasonable alternatives or variant treatments, attendant risks and benefits, implications, complications and their significance in my circumstances have been thoroughly discussed. I hereby authorise Prof Azzopardi to perform a specialist bespoke laser treatment on me.

*My questions regarding my treatment, its complications and its side effects have been answered. I certify that I have read and fully understand the above and I have had sufficient opportunity to discuss this and to ask questions.*

***By signing this consent form, I am hereby accepting that:***

*I have read this form accept the risk and request to proceed nonetheless.*

*ALL the options and reasonable alternatives or variant treatments including in relation to NOT having the treatment in question carried out have been explained in full. This includes the material risks, benefits and implications in my specific circumstances.*

*I have been given every opportunity to raise questions, in advance of the procedure in question, and these have been appropriately answered to my satisfaction.*

*I have been offered a letter, and I have been advised to forward this to my GP if I am happy with sharing this information with said GP.*

*I confirm that consent discussions have taken place on at least two occasions with a cooling off period in between, with at least one consultation held face to face.*

*That on occasion, I may be followed up by another suitably qualified professional, at the appropriate additional charge.*

*That I consent to sharing my details with another health professional when this is deemed in my interest.*

*The risks and possibilities explained to me with regard to this treatment are equally applicable to similar future treatments I may receive on a rolling basis until I request cessation of treatment in writing.*

*In addition I declare I have read and agree to the terms and conditions document in force at the time of signing, available on* [*www.skinsurgeon.eu*](http://www.skinsurgeon.eu)*.*

*I agree to the terms and conditions imposed by the place of practice, without prejudice to this agreeement.*

*I further declare that I have not undergone any cosmetic surgery or interventions of any sort by any unlicensed third party or by any professional or entity situated in Turkey.*

*I agree that complaints will be in the first instance subject to inhouse complaint handling service, and if subsequently necessary an external review process.*

*Jurisdiction and territory: Treatment undertaken is subject to jurisdiction of the same territory, absolutely. I hereby irrevocably waive the right to alternative jurisdictions especially the United States of America.*

I hereby declare that I have read and understood the product advisory leaflet and summary of product characteristics sheet. All questions regarding my treatment, its complications and its side effects have been answered. I hereby give my informed consent to the procedure.

PATIENT

DATE

Prof Ernest Azzopardi

Consultant

DATE

**Optional: I consent to having photographs and authorise their anonymous use for the purpose of audit, education and promotion on written and electronic media including social media, scientific publication.**

**Yes NO ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_**