THE DERMATOLOGY CLINIC

INFORMED CONSENT FOR SURGERY

Last Updated: 10/5/2013

Patient: _____ Date: _____ Time: _____

I am scheduled for outpatient surgery on_____

I am scheduled to have a(n): _____

to be performed by _____and such assistants as may be selected by her.

I have been informed, and I understand to my satisfaction, the above---mentioned procedure(s), why it is necessary, the risks to my health if the condition remains untreated, and what the procedure will entail. I herein give my permission for the procedure above and administration of pre-surgery medication and anesthesia (local or general) for outpatient surgery.

The advantages and disadvantages of the outpatient surgery have been explained to me as the procedure that will be performed on me. Admission to a hospital might be advised after the procedure. I agree to admission to the hospital of choice by the performing surgeon, if in her opinion such admission would be advised.

I understand that during the course of operation, unforeseen conditions may be revealed that necessitates an extension of the original procedure or different procedure than those planned. I authorize the above named surgeon to perform such surgical procedure(s) as are necessary and desirable in the exercise of professional judgment.

I have been made aware that there are certain risks inherent to the performing of any surgical procedure such as: loss of blood, infection, hematoma, pain, tingling, numbness or other nerve sensations including nerve damage, reactions to anesthesia and the formation of thick or otherwise objectionable scars. Additionally, I acknowledge that the doctor has made no promises to me, oral or written, in connection with the operation. I recognize that every surgical procedure involves uncertainty and that no results can ever be guaranteed.

Following surgery, I will/ will not have a responsible adult drive me home as per previous arrangements. I realize that impairment of full mental alertness may persist for several hours following the administration of anesthesia, and I will avoid making decisions, and/or taking part in activities that depend upon full concentration or judgment during that period.

I release the doctor from responsibility any event that occurs as a natural complication of the procedure. I also realize it is my responsibility to keep postoperative appointments. If I feel any problems exist such as bleeding, infection, or if I have any doubts, I am to contact the doctor as soon as possible. For the purpose of advancing medical education, I consent to photographing and/or recording of the operation, provided my identity is not revealed by the pictures, or descriptive text accompanying them. In addition, I consent to the disposal of any tissue that is removed in accordance with accustomed practice and procedure. I give my permission to have any tissue removed during the procedure sent for histologic examination to a pathologist.

_____ _____

Patient/ Guardian Signature: Relationship Date

_____ _____

Witness Signature Date

_____ _____

Physician Signature Date

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