THE DERMATOLOGY CLINIC
OF ARKANSAS

CONSENT FOR SURGICAL EXCISION

NATURE AND EXTENT OF PROCEDURES:

Surgical excision for removal of a _____ located on the _____ and possible repair of the resulting defect (surgical wound/hole), left by the removal of the skin lesion.

1. I, _____,do hereby consent and agree to have surgery performed by the physicians and staff at The Dermatology Clinic. I consent to any other medical services, which during the procedure become medically reasonable and necessary. This includes the administration of anesthetics and/or sedatives necessary to perform the surgery, with any exceptions noted here:

2. I consent for repair of the defect left by the removal of the tumor. This repair will be a separate procedure and may be performed at The Dermatology Clinic or Spring Creek Surgery Center at my doctor's discretion.

3. I fully understand the results that I may reasonably expect. I understand the results of surgical repairs are not perfect. An explanation of this procedure has been given to me. I have had the opportunity to ask any questions regarding this procedure.

4. The pros, cons and alternatives to surgery have been explained. I have chosen surgical excision.

5. I understand every time an incision is made on the human skin, a scar will occur, although every effort will be made to make the scar inconspicuous. Superficial crusting, pinkness, or redness of the incision area may occur, but these will likely be temporary. A thickened or raised scar (a hypertrophic scar/keloid) is possible. This is more likely to occur in patients with a history of this type of scarring.

6. In addition to scarring, other possible side effects are:

1. **Temporary redness or severe permanent scarring**
2. **Tenderness of the scar and/or darker or lighter scars (depending on your genetic make- up)**
3. **Risk of keloids and wide scars**
4. **Complications, such as bleeding, infection, hematoma, wound breakdown and opening, long term pain, and nerve damage, can occur**
5. **Transient tingling or "drawing sensation" may occur for some time, as nerve regeneration and scar maturation may take up to one year**
6. **Permanent pain in scar area**

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7. I consent to the photography or televising of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures or by descriptive text accompanying them.

8. For the purpose of advancing medical education, I consent to the admittance of observers to the operating room.

9. I am voluntarily authorizing the procedures and treatments.

10. I believe I have been well informed and understand that the practices of medicine and surgery are not exact sciences. I understand knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results.

11. This consent was read and signed while not under the influence of medications which cause drowsiness.

12. I certify this form has been read or it has been read to me, the blank spaces have been filled in, and I understand its contents.

13. Some postoperative discomfort may be experienced.

14. I have had opportunities to ask questions.

15. I acknowledge I am responsible for payment of these services with no fee reimbursement regardless of procedure results. I have not been guaranteed a specific result. I understand the fee paid is for the procedure and not for an expected result.

_____ _____

Patient or Legal Responsible Person Patient Name Printed

_____

Witness

Date: _____ Time: _____ am / pm

PLEASE NOTE

ADDITIONAL STAINS MAY BE REQUIRED TO DIAGNOSE THIS BIOPSY. THIS WILL INCUR ADDITIONAL CHARGES TO BE DETERMINED BY THE PATHOLOGIST.