

## SURGICAL & THERAPEUTIC PROCEDURE CONSENT FORM

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

Dr. Frank Armstong has discussed with you your condition and the recommended surgical procedure to be performed. This discussion was intended to ensure that you had the opportunity to receive the information necessary to make a reasoned and informed decision whether or not to consent to the procedure. This document is written confirmation of that discussion and contains some of the more significant medical information discussed.

1. Based on this discussion, I understand the following condition may exist in my case:

\_\_\_\_\_

2. I understand the procedure proposed for treating or diagnosing my condition is:

\_\_\_\_\_

3. I have been informed of the purpose and reasonable expected benefits of the proposed procedure, the probability of success or failure, major problems of recuperation, the reasonably anticipated consequences if the procedure is not performed, and the available alternatives. Some of the surgical alternatives include: Destruction of tissue (Cryosurgery, ED&C, Radiation), Surgical Excision, or MOHS surgery. Alternatives for healing include: Primary Closure, Granulation, Graft, or Skin Flap.

4. I understand that all surgical and therapeutic procedures involve some risks to some degree. These risks may include, but are not limited to, the potential for infection, allergic reaction, pain, scarring, keloid, swelling, erythema, peeling, hypopigmentation, hyperpigmentation, blister or crust formation, injury to blood vessels and/or bleeding, bruising, hematoma, injury to nerves and/or numbness, incomplete removal of the lesion(s), recurrence of the lesion(s) and/or symptoms, and the need for further treatment and/or surgery. In addition to the potential risks listed above, intralesional steroid injections include, but are not limited to, the potential for skin/subcutaneous tissue atrophy, striae, HPA suppression, hypertension, hyperglycemia, psychiatric disorders, osteoporosis, and development of superficial blood vessels.

5. I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedures. Although the benefits are judged to outweigh the risks, should any complications occur, any one of them could be permanent. I hereby voluntarily give my authorization and consent to Dr. Frank Armstrong to perform the proposed procedure described above.

6. I consent to the administration of local anesthetics as may be considered necessary or advisable by the provider responsible for this service. I hereby consent to the administration of anesthesia by Dr. Frank Armstong or his medical assistants. I consent to the administration of the following local anesthetics:

1% Lidocaine with Epinephrine                      Other \_\_\_\_\_

7. I hereby authorize and consent to the disposal of tissue necessarily removed as a part of the procedure for diagnostic purposes.

8. I have been given the opportunity to ask questions about my condition, alternative forms of treatment, risks of non treatment, the procedure to be used, and the risks and hazards involved. I believe I have sufficient information to give this informed consent.

9. **I UNDERSTAND THAT AN INDEPENDENT LABORATORY MAY BILL ME. LABORATORY BILLING IS NOT PART OF ARMSTRONG DERMATOLOGY & SKIN CANCER CENTER P.A. BILLING – PLEASE CONTACT THE LABORATORY DIRECTLY IF YOU RECEIVE A BILL.**

I certify I have read and fully understand the contents of this form, that the disclosure referred to above were made to me, and that all blanks and statements requiring insertion or completion were filled in before I signed my name below.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If patient is a minor or unable to give consent,  
Signature of person authorized to consent for patient: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_