Practice Logo

INFORMED CONSENT FOR MINOR SURGICAL PROCEDURES

This form authorizes *PHYSICIAN NAME* to perform the following procedure(s):

☐ Liquid Nitrogen Destruction/Freezing: _____
- A gaseous spray applied to the skin at a temperature of -196˚F with the intent to destroy tissue.

Risks inherent to the performance of cryotherapy are redness, blistering, infection, numbness and/or lack of sensation, hypo- or hyperpigmentation, formation of scars, recurrence, and the possibility that further treatment to the area may be necessary.

☐ Shave Biopsy:_____
- The use of a sterile flexible surgical blade to remove a small piece of tissue for pathology.

☐ Punch Biopsy:_____
- The use of a sharp sterile tubular instrument to remove a small plug of tissue for pathology, and the remaining defect closed with sutures.

☐ Incision and Drainage/I&D:_____
- The use of a scalpel to lance the skin and remove the contents of a cyst or abscess.

☐ Scissor Snip Excision:_____
- The use of sterile scissors and forceps to remove a small piece of tissue.

☐ Curettage:_____
- The use of a sterile sharp round or oval ended instrument to scrape off tissue.

☐ Other:_____

Risks inherent to the performance of any surgical procedure are loss of blood, infection, reaction to anesthesia, numbness and/or lack of sensation, formation of scars, recurrence and the possibility that further treatment to the area may be necessary.

I have been informed in non-surgical language that I understand the nature of the procedure(s) and why it is necessary.

I have also been informed and I understand the risks associated with the procedure(s). I give my permission to have any tissue(s) removed during the procedure(s) to be sent for histological examination by a pathologist if necessary.

_____ _____

Signature of the patient/legal guardian Date

_____

Witness