**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**CONSENT FORM FOR EXTRACTION**

(Please acknowledge the source when using this consent form)

Mr/Mrs./Miss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_ Hospital ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the PROCEDURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Procedure Details:**

* Extraction is an acne surgery where blackheads white heads are gently removed , inflamed acne drained .The doctor has explained to me the anticipated benefits of the procedure, the risks, the alternatives, the risks associated with the alternatives.
* I understand that the practice of medicine is not exact science and that no guarantee can be made regarding the outcome of my planned procedure. Therefore, no guarantee, warranty has been made to me as to the result that may be obtained.
* My doctor has explained to me that this procedure is generally safe but that certain risks accompany any surgical procedure.Risks associated with acne extraction include;
1. Pain, Bleeding and bruising in the surrounding tissues,
2. Dyspigmentation esp hyperpigmentation which can be treated in most cases
* It is very possible that this procedure may fail to achieve my desired results. Strict adherence to pre and post-op instructions is essential. I may need to repeat treatment to achieve desired results.

**COST AND PAYMENT**

I have been informed about the fees and the number of sessions / package. I shall abide by the same

**C****onsent Letter :**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and her /his designated staff to perform procedure of extraction. Further, my signature below indicates my consent for the treatment described and my agreement to comply with the requirements placed on me by this consent form.

I have informed the doctor about my medical history regarding herpes, allergy, acne, keloids, diabetes, and autoimmune disease, treatment with anticoagulants, NSAIDS, blood thinners or corticosteroids etc. I have been informed about the other alternative methods as well as their benefits and disadvantages.

 No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. I am also aware that follow-up treatments may be necessary for desired results. I understand the procedure, the risks, complications and after care.

I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however, my name or identity will not be disclosed, and complete confidentiality will be maintained.

My questions regarding the procedure have been answered satisfactorily.

I hereby release Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and her/his designated staff from any liability and side effects associated with above procedure.

**SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE (in case of minor)**

**Name:**

**SIGNATURE OF WITNESS SIGNATURE OF OPERATING DOCTOR**

**Name: Name:**

**Date: Time: Place:**

**Was Translation to the Patient’s language required: Yes/ No**

**SIGNATURE OF THE TRANSLATOR**

**(Name and Relationship with the patient, if any)**