**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**CONSENT FORM FOR CRYOTHERAPY**

(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:**

* Cryotherapy is the destruction of tissue by freezing it . Doctors commonly use liquid nitrogen to freeze tissue.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 usually prior to treatment no Anesthesia is required and there is only mild discomfort during the procedure.
* The duration of spray , number of cycles depends on the nature of target lesion. Most lesions require multiple sessions spaced several weeks apart.
* Post treatment blistering followed by scabbing occurs which falls of in a few weeks.
* 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 cryotherapy include
1. Redness , swelling and blistering
2. Pain associated with the surgery or the healing process
3. Long standing dyspigmentation ( esp hypopigmentation)
4. Delayed healing Excessive scarring, keloidal formation, milia formation at the surgery site
5. Local infection
6. Damage to the structure below the skin such as nerves
* I understand that there are alternatives to this procedure such as s excision , electrosurgical or laser destruction. The advantages /disadvantages have been explained to me. I understand I can refuse the surgical removal procedure.
* I understand that the unforeseen conditions may alter the planned procedure if necessary, or to administer anaesthetics or other medications, if I should need them for the completion of my procedure.
* 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.
* After getting the procedure done, I will follow the instructions given by doctor
* Clinical results may vary between individuals, sessions and scars. I am fully aware that it is to improve the healing of scars eventually.

**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 cryosurgery. 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, Raynaud’s 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. ( including radio frequency, laser)

I understand the effect of the treatment can last for months/years. However, the duration may be variable depending on the area treated, skin type, and the technique used. 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. I also agree to comply with the recommended aftercare instructions.

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

**Name:**

**Date: Time :**

**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)**