**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**CONSENT FORM FOR ELECTROCAUTERY**

(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:**

ELECTROCAUTERY is used for controlled destruction of tissue.The doctor has explained to me the anticipated benefits of the procedure, the risks, the alternatives( including laser , cryotherapy), the risks associated with the alternatives.I also understand the consequences of not undergoing any treatment for my condition.

* I understand that prior to treatment, the area to be treated will be anesthesized with a topical anaesthetic (numbing) cream or lidocaine injection.
* 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 electrocautery include;
1. Bleeding and bruising in the surrounding tissues
2. Pain associated with the surgery or the healing process.
3. Delayed healing , Excessive scarring , keloid formation , dyspigmentation at the surgery site.
4. Allergic reaction to the anaesthetic medicine or the surgical instruments.
5. Local infection in the surrounding tissue.
6. Damage to the structure below the skin such as nerves or blood vessels
* I understand that the unforeseen conditions may alter the planned procedure, if necessary, or to administer additional anaesthetics or other medications, if I should need them for the completion of my procedure.
* I understand that Strict adherence to pre and post-procedure instructions is essential.
* Strict photoprotection is important to reduce the risk of hyperpigmentation.
* I understand that Histopathological examination may not be accurate when lesion is treated with ELECTROCAUTERY

**COST AND PAYMENT**

I have been informed about the fees and I shall abide by the same

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

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and her /his designated staff to perform procedure of electrocautery . 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 pacemakers, other metal implants , epilepsy, herpes, allergy, acne, keloids, diabetes, and autoimmune disease, treatment with anticoagulants, NSAIDS, blood thinners or corticosteroids etc. I am not pregnant or breast-feeding. In spite of this, I am aware that I may develop any allergy at any point.

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

I have been given ample opportunity to ask questions and all my doubts have been clarified to my satisfaction by the doctor.

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:**

**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)**