**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**CONSENT FORM FOR SKIN BIOPSY**

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

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

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

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

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

Differential Diagnoses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Procedure Details:**

* The purpose of this procedure is to take a small skin sample to be examined under microscope . The doctor has explained the anticipated benefits of the procedure, the risks, the alternatives, the risks associated with the alternatives.
* I understand that prior to treatment, the area to be treated will be anesthetized with a topical anaesthetic (numbing) cream or lidocaine injection.
* My doctor has explained to me that this procedure is generally safe, straightforward but that certain risks accompany any surgical procedure.Risks associated with punch biopsy 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 (such as taking more than one sample of skin), 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.
* I understand that Histopathological examination may not help in arriving at a diagnosis 100 % of the time and the procedure may have to be repeated if deemed necessary.

**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 skin biopsy . 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 am not pregnant or breast-feeding. In spite of this, I am aware that I may develop any allergy at any point. I give my consent to the doctor to take the necessary measures to treat my allergic reaction, if any develops.

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)**