**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**(2019-2020)**

**Consent form for Acne Scar Surgery**

(Please acknowledge the source when using this consent form)

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

**Age: Date:**

**Case Record No:**

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

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

**Diagnosis:**

**Name of the PROCEDURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I HAVE BEEN INFORMED THAT**

* The purpose of this procedure is to reduce some or most of facial acne scars and may require multiple sequential treatments.
* Prior to treatment, the area to be treated will be anesthetized with a topical anaesthetic (numbing) cream or lidocaine injection. You may be given Diazepam for your comfort prior to treatment.
* Following treatment, you may experience pain, swelling and redness and bruising.
* Risks associated with this procedure include, but are not limited to the following:
1. Pain- Stinging or sharp pain may be present after the procedure and throughout the healing process
2. Bruising- This treatment will cause significant bruising of the treated area. The bruising may be present for weeks.
3. Swelling- Swelling will be present after the procedure and is likely to resolve after 1-2 weeks
4. Pigmentary changes- The treated area may heal with altered pigmentation - either darker or lighter skin.
5. Scarring- There is a risk of scarring with this procedure any time during healing process. Nodules may form at needle insertion sites.
6. Bleeding- The procedure will cause bleeding, sometimes significant, which should stop within few minutes without any lasting effect when pressure is applied. The bleeding may not reach upper level of the skin and may result in bruises of the skin. The red colour will darken to purple and purple yellow and will disappear in 1-2 weeks.
7. Scabbing- A scab may be present at some of the surgery sites. The scabbing will disappear during natural healing.
8. Infection- Infection of the wound is always possible. Any significant infection must be brought to our attention as soon as possible. Such signs are excessive pain, swelling, redness or drainage/pus. Any infection could last for 7-10 days and could lead to scarring.
* 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 your treatment to achieve desired results.
* After getting the procedure done, I will follow the instructions given by the doctor.
* Clinical results may vary between individuals, sessions and scars. I am fully aware that it is to improve the healing of scars eventually.

**I WAS ALSO INFORMED ABOUT**

* The other alternative methods of acne scars as well as their benefits and disadvantages.
* No guarantee, warranty or assurance has been made to me as to the result that may be obtained.
* I am also aware that follow up is necessary and multiple sessions are required for optimum healing of scars.

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**ADDITIONALLY**

* I agree that any pictures taken of my treatment site may be used for publication or teaching purpose; however, my name or identity will not be disclosed and complete confidentially will be maintained.
* By signing below, I acknowledge that I have read about the adverse reactions above and feel that I have been adequately informed of the possible risks of the procedure.
* I have informed the doctor about any/all drug allergies that I have.
* Before each treatment, I will inform the doctor if I have taken any new medications since my last visit.
* I also agree to comply with the recommended aftercare instructions.
* My questions regarding the procedure have been answered satisfactorily.

**Consent**

I authorize Dr ----------------------- and her /his designated staff to perform procedure. 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 hereby release Dr ------------------ and her/his designated staff from any liability associated with above procedure. The payment and fee structure have been informed to me and I agree to abide by the same.

**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)**