**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**2019-2020**

**Consent form for Cyst Removal**

(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 the removal of epidermoid (sebaceous) cyst. 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 prior to treatment, the area to be treated will be anesthetized with a topical anaesthetic (numbing) cream or lidocaine injection. I may be given diazepam for my comfort prior to treatment.
* I understand that the doctor may attempt removal of cyst through a small incision. If the cyst is scarred, it may require the standard removal technique through a larger incision. I understand that my doctor will attempt to remove the entire wall of the cyst so that it does not recur.
* 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 cyst removal include;
1. Bleeding and bruising in the surrounding tissues
2. Pain associated with the surgery or the healing process.
3. Excessive scarring 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.
7. Extremely rare, unusual reactions including possible death following any surgical procedure.
8. Keloidal changes may occur during healing
9. Cyst may reccur
10. There may be delayed wound healing/ excess granutaion tissue formation at the wound site
* I understand that there are alternatives to this procedure such as simple incision and drainage, placement of iodine crystals into cyst, electrosurgical or laser destruction or freezing (cryosurgery) of the cyst. 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 (such as switching to the standard removal technique using a large incision), if necessary, or to administer additional 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.

**Consent**

* I have read this form and other information forms provided to me by the doctor and understood the information contained within this form.
* I have had my questions answered to my satisfaction. I accept the risks and complications of the procedure and authorize Dr ----------------------- and her /his designated staff, the doctor deems appropriate to perform procedure.
* Further my signature below indicates my consent to the treatment described and my agreement to comply with the requirements placed on me by this consent form.
* I also authorize administration of sedation and/ or anaesthesia as may be deemed advisable or necessary for my comfort, wellbeing and safety.
* 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
* I hereby release Dr ------------------ and her/his designated staff from liability 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)**