**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**2019-2020**

**Consent form for Intralesional Corticosteroid Injection in Keloids**

(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 the hardness and soften the keloid. Multiple sessions are required for it.
* In this procedure, my keloid will be targeted and intralesional steroid will be given, that is likely to cause mild pain during injection.
* After getting the procedure done, I will follow the instructions given by doctor and I will also be required to take some other medications prescribed by the doctor.
* Clinical results may vary between individuals and sessions.
* I am fully aware that it will require multiple sessions to reduce my keloid.

**I WAS ALSO INFORMED ABOUT**

* The other alternative methods for dealing with keloids like cryotherapy, 5-fluorouracil and their benefits and disadvantages.
* I understand that for ideal results it can be combined with cryotherapy and 5-Fluorouracil injections.
* 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 desired results.

**I ALSO UNDERSTAND THAT**

* Short term side effects may include pain during injection, allergy, bruising.
* After the procedure, hyper or hypo pigmentation can occur at the injection site.
* There may be necrosis, atrophy or telangiectasia.
* In case of pain or any secondary infection, I may need to take analgesics or antibiotics respectively.

**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 the adverse reactions above and feel that I have been adequately informed of the possible risks.
* 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.

**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.

My questions regarding the procedure have been answered satisfactorily.

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)**