**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**2019-2020**

**Consent form for Mole Removal 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**

1. About the potential benefits of the procedure of mole removal and biopsy. However, I understand there is no certainty that I will achieve these benefits
2. No guarantee, warranty or assurance has been made to me regarding the outcome of the procedure.
3. The reasonable alternative(s) to the procedure, as well as the risks of alternatives have been explained to me by the doctor. The alternatives include, but are not limited to leaving the mole or tissue in place, which may or may not be cancer.
4. The doctor has explained to me that there are risks and possible undesirable consequences associated with this process including, but not limited to blood loss, infection, heart complications, blood clots, loss of or loss of use of body parts, other neurological injury, recurrence, scarring, reaction to the local anesthetic if used and/ or death.
5. In the event any of the inherent complications mentioned above, may occur, my doctor and his team will take appropriate and reasonable steps to help manage the clinical situation and be available to me and to my family to address our concerns and questions.
6. Any of the above risks or complications may require further surgical interventions during or after the procedure, which I expressly authorize. In the event of any of the inherent complications mentioned above, occurring, my doctor and his team will take appropriate and reasonable steps to help manage the clinical situation and be available to me and to my family to address our concerns and questions.
7. I understand that if I need blood or blood products, these carry a risk of contracting HIV/AIDS, hepatitis or other diseases.
8. I have been explained that clinical results may vary between individuals, sessions and scars. I am aware that it is to improve the healing of the scars eventually.

**ADDITIONALLY**

1. I --------------------------------- hereby authorize Dr----------------------------and any associate or assistant the doctor deems appropriate, to perform mole removal with biopsy.
2. I also authorize the administration of sedative and /or anesthesia as may be deemed advisable or necessary for my comfort, wellbeing and safety.
3. In permitting my doctor to perform the procedure, I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure or different procedure(s) than those already explained to me. I therefore authorize the doctor and his team, perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.
4. In the event any of the inherent complications mentioned above, may occur, my doctor and his team will take appropriate and reasonable steps to help manage the clinical situation and be available to me and to my family to address our concerns and questions.
5. I authorize the doctor/hospital to utilize or dispose the removed tissues, parts of organs resulting from the procedure authorized above.
6. I consent to my photographing/video graphing of the procedure that may be performed, provided my identity is not revealed by the pictures or the descriptive texts accompanying them.
7. I consent to the admittance of students or authorized equipment representatives to the procedure room for purpose of advancing medical education or obtaining important product information.
8. I have informed the doctor about any /all drug allergies that I have. I also agree to comply with the recommended aftercare instructions

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and all of my questions have been answered to my satisfaction.

I hereby release Dr------------ and his/her designated staff from liability associated with the above procedure. I authorize Dr -------------- and his /her designated staff to perform procedure.

**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)**