**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**2019-2020**

**Consent form for Scar Revision 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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Site and Brief description of scar\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I HAVE BEEN INFORMED THAT**

* It is impossible to completely remove the scar.
* The aim of the surgical procedure is to replace an ugly/more apparent scar to a less apparent and aesthetically better scar.
* There are many different techniques of scar revision surgery. The type of surgery may depend on the type of scar, site of scar and surgeons expertize. In addition to surgery there are other modalities like laser therapy, dermabrasion, Microneedling, chemical peels etc. I have been offered the option to discuss these various therapies before opting for surgery.
* This procedure is performed under local anesthesia. A few injections will be given at the site of surgery to make the area numb. There after the procedure is expected to be painless.
* The operated site will be secured with help of sutures (stiches) in one or multiple layers and a small bandage will be put to cover the wound.
* Any surgery can have potential complications. They include pain, swelling, bleeding, infection, scarring, discoloration of skin, irregularity of contour of skin, allergic reaction to the suture material, delayed wound healing, hypertrophic scar, keloid formation etc. These complications do not occur in all patients and can be minimized to some extent with surgical expertise. Some amount of pain, swelling and discomfort is expected at the site of operation. For this a course of antibiotics and painkillers will be prescribed to me. In case pain or swelling is severe I need to contact my doctor immediately.
* Very rarely serious cardiac, pulmonary or neurological complications can occur.
* During post-operative period, I will avoid any activity which can produce tension at the operated site
* I will try to keep the area dry
* I will be called after 5-7 days after surgery for stich removal.
* In the initial stages the scar is red and elevated above the skin. In due course of time the scar becomes more or less skin coloured and also tends to flatten with time. This process may take up to a year.
* Clinical results may vary between individuals.
* No guarantee, warranty, or assurance has been made to me as to the results that may be obtained.
* I am also aware that follow-up treatments may be necessary for desired results.
* Smoking, tobacco products, or nicotine products (patch, gum, or nasal spray) are at a great risk for significant surgical complications of skin dying, delayed healing, and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure.
* Following is my current status regarding smoking
  + \_\_\_\_\_\_\_ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.
  + \_\_\_\_\_\_\_ I am a smoker or use tobacco/ nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

**Additionally**

* I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however, my name or identity will not be disclosed and complete confidentiality will be maintained.
* By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the possible risks of scar revision
* 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 treatment.
* I also agree to comply with the recommended aftercare instructions.
* I consent to the disposal of any tissue, medical devices, or body parts which may be removed.

**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 same have been adequately answered.

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)**