**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**2019-2020**

**Consent form for Vitiligo 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. Vitiligo is a disease with a chronic, recurrent course.
2. I am aware that surgery is only a cosmetic procedure and other concomitant medical treatments may be essential. Surgery will not alter the course of the disease or prevent any recurrence.
3. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure.
4. My disease/ white patches has/have not been increasing in size or number for the last-------months. I have no tendency for keloids.
5. I am aware that the exact course of the disease cannot be predicted and, though the disease is stable at present, flare-ups and recurrences may occur at any time, in any part of the body.
6. I have been explained the procedure of the operation as follows:
	1. The procedure will be done under topical/local anesthesia.
	2. The donor area is from back/thigh/gluteal area/inner arm.
	3. The donor graft will be taken by punch/suction blister/grafting knife/dermatome.
	4. Recipient area will be abraded by dermabrader and then the graft applied, covered by dressing.
7. I am aware that avoiding movements and taking care of the recipient area is essential for optimal results.
8. I am aware that I may experience some pain postoperatively and may need to take analgesics.
9. Donor area will need dressing; the donor area may take 2-3 weeks to heal.
10. I am aware that for optimal cosmetic results, it may take six months to one year. I may need to take medical treatment and phototherapy during this period.
11. I am also aware that the grafted area may not match in texture and appearance with the surrounding skin. A perfect match with the surrounding normal skin may not always be possible.
12. I consent to be photographed/videographed before, during, and after the treatment; that these photographs/videos shall be the property of the above doctors and may be published in scientific journals and/or shown for scientific reasons.
13. I agree to keep the doctors informed of any change of address so that they can notify me of any late findings, and I agree to cooperate with the above doctors in my care after surgery until completely discharged.
14. I am not known to be allergic to anything except: **(mention if any….)**
15. I have read the above consent. I fully understand the contents of the consent and authorize and request the above doctors to perform this surgical procedure on me. The consent form has been signed by me when i was not under the influence of any drugs.

**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)**