

## Informed Consent Form

### Dermal Electrosurgical Shave Excision

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

1. I hereby authorize Dr. \_\_\_\_\_ to perform the procedure known as the dermal electrosurgical shave excision.
2. I understand that this is a procedure performed under local anesthesia to remove skin growths or tumors. I understand that the doctor will attempt to remove the entire lesion to prevent regrowth, while also trying to optimize the final cosmetic result. I understand that this procedure usually yields acceptable scars, but that each person heals differently. I understand that the practice of medicine is not an exact science, and that no guarantee can be made regarding the outcome of my planned procedure.
3. My doctor has explained to me that this procedure is generally safe, but that certain risks accompany any surgical procedure. Risks associated with the dermal electrosurgical shave excision procedure include the following:
  - Bleeding from the surgical site
  - Unintentional burn to skin (either nearby or distant)
  - Damage to structures or tissues beneath the treatment site
  - Excessive scarring from the procedure
  - Allergic reaction to the medications or surgical instruments
  - Infection in the tissues after the procedure
  - Rare, unusual reactions, including possible death, following any surgical procedure
4. I understand that there are alternatives to this procedure, including full-thickness skin excision, laser destruction, freezing or cryotherapy, or chemical destruction of the growth. I understand that the alternate procedures may not yield the same benefits as the shave excision procedure. I understand that I can refuse this procedure.
5. I understand that unforeseen conditions may alter the planned procedure. I give permission to my doctor to alter the procedure (such as to remove the skin growth by performing a standard excision), if necessary, or to administer additional anesthetics or other medicines if I should need them for the completion of my procedure.
6. I have read this form and other information forms given to me by my doctor. I have had my questions answered to my satisfaction.

Witness: \_\_\_\_\_ Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Minor: \_\_\_\_\_ Parent: \_\_\_\_\_

Adapted with permission from Zuber TJ. Office procedures. Baltimore: Lippincott Williams & Wilkins, 1999.