**SURGERY CONSENT FORM (IN OFFICE)**

The surgical procedure or treatment to be performed is a:

* Skin biopsy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Removal of lesion/tumor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to the surgical procedure or treatment that has been explained to me by **Dr. Richelle Knowles**. I understand that the following are possible risks involved:

* Pain, swelling, itching and irritation
* Bleeding from injury to the blood vessels
* Infection from a break in the skin surface *(due to picking or poor wound care)*
* Reaction to anaesthesia, topical antibiotics or adhesive tape
* Skin discoloration (hypo or hyperpigmentation)
* Persistent redness
* Local nerve damage or numbness
* Wound dehiscence (a pulling apart of the wound edges from injury after the sutures are removed) due to physical stress to the wound and/ trauma to the wound after suture removal.
* Scar formation (which can sometimes look worse than the original lesion)
* Recurrence of the lesion(s)

I understand there may be other methods to do this procedure, but agree to the procedure as stated above, understanding all the risks involved. I have been given the opportunity to ask all my questions regarding the procedure and its risks. I agree that photographs may be taken. I understand that specimens may be sent for microscopic evaluation.

This is an elective procedure and is being done at my request. I have been informed and given detailed information as to prepare me for my procedure. \_\_\_\_\_\_\_\_\_\_\_\_  
 Patient’s initials

I hereby release **Dr. Richelle Knowles** from any responsibility that may take place as a natural complication of the procedure.

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Patient’s signature Guardian’s signature, if applicable

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_