Phone: (919) 363-7546 Fax: (919) 363-3616

American College of Mohs Surgery
Fellowship trained skin cancer and reconstructive surgeons

CARY SKIN CENTER
Skin Cancer Center

Informed Consent for Minor Surgery *FORM E*

My signature on this form authorizes *Dr. Clark, Dr. Ingraffea, Dr. Eickstaedt, and/or their associates* to perform the following procedure:

☐ Surgical excision for: _____

☐ Nail Unit Biopsy for: _____

☐ Other: _____

WHAT ARE THE POTENTIAL COMPLICATIONS AND SIDE EFFECTS OF SKIN SURGERY?

1. **PAIN:** Some mild discomfort is experienced when the area is first anesthetized with the numbing medication. You may experience some mild discomfort during the procedure if the numbing medication has worn off in a particular location. This is easily remedied by immediately giving more anesthetic in that area. After the procedure some discomfort will be experienced at the surgical site. This is easily controlled with pain medications for a few days.

2. INFECTION: Any time that the skin is injured an infection is possible. The rate of infection is very low. Some patients will receive postoperative antibiotics to prevent an infection. If you feel that your wound is infected after surgery please call our office immediately**.**

3. BLEEDING: When you leave our office you will have a pressure bandage applied to your wound. Bleeding is always possible after surgery. Most cases of postoperative bleeding are easily stopped by applying pressure for 20 minutes over the site. If this does not work please call our office immediately.

4. SWELLING: After surgery you should expect some swelling where your surgery was performed and around the wound as well.

5. **HEMATOMA:** A hematoma is a collection of blood that forms under the skin. This results from bleeding that occurs after the surgery. A "lump" forms under the skin, which represents the dried blood. If this occurs call our office immediately.

6. **SCAR FORMATION**: Any time that the skin is injured a scar will form. Some scars are more noticeable than others, but a scar is always present. A scar will form after your surgery. Hypertrophic and keloidal scarring are possible. If you have a history of bad scarring please advise us at the time of your visit. The cosmetic appearance following surgery is unpredictable.

7. WOUND DEHISCENCE: This means that your wound has broken back open after it has been repaired with sutures. It is very important to take it easy after your surgery so that unnecessary strain is not placed on the wound. This is an uncommon complication.

8. FAILURE OF FLAP OR SKIN GRAFT: After your surgery is completed we will need to repair the wound. Some patients are repaired with either a flap or skin graft. A flap is when skin is borrowed from a nearby site to close the defect. A skin graft is when a piece of skin is taken from one site and transplanted to another. A possible complication is the failure of either of these to take at the new site. Smoking is a documented risk for this complication. If you are a smoker it is recommended that you discontinue smoking for one week before and after the procedure.

9. TEMPORARY OR PERMANENT NERVE DAMAGE: The primary goal of your surgery is to completely remove the tumor. In order to accomplish this, it is sometimes necessary to damage a nerve. Nerve damage can be temporary or permanent. Recovery usually takes 6 months or more, and rarely can require additional surgery. Nerve damage may be limited to a loss of sensation or may include paralysis.

10. DISTORTION/ALTERATION OF SURROUNDING ANATOMIC FEATURES: The repair or healing of surgical wounds may distort the appearance of adjacent structures. Our goal is to completely remove your skin cancer, and then concern ourselves with the function and appearance of surrounding anatomic structures.

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The complications of surgery are not limited to the above list.

I acknowledge that I have read the entire consent form. I understand its contents, and the doctor and/or his associate, has adequately informed me of the risks, benefits, advantages, disadvantages, alternatives, and possible complications of skin surgery. I also understand that the postoperative size of the surgical wound after removing the skin cancer, and the method of repair can not be predicted in advance, and I could require referral for additional closure or revision of the procedure site.

I further request the administration of such analgesia and/or sedative medication as deemed necessary or desirable for the completion of the procedure. I understand that the administration of medication carries risks separate and apart from the risks of the procedure.

I recognize that the results from the practice of medicine and surgery are not absolutely predictable, and I acknowledge that no guarantees or assurances have or can be made concerning the results of such treatment. I further acknowledge that there have specifically been no guarantees as to the cosmetic results from the procedure.

All of my questions and concerns have been answered by Dr. Clark, Dr. Ingraffea, Dr. Eickstaedt, and/or their associates. _____

I also consent to the taking of photographs before, during, and after the procedure. These photographs are important to document and follow your progress after surgery. These photographs will belong to Cary Skin Center, and may be used for research, educational, and scientific purposes. This may include presentation at lectures or publication in medical journals. In such an event, I will not be identified by name. I expect no compensation for any such use of these photographs, and I waive all my rights to any claims for payment or royalties. I also release Dr. Clark, Dr. Ingraffea, Dr. Eickstaedt, and/or their associates/assistants from any liability in connection with the use of such photographs.

I agree that any tissue removed during the course of the operation may be examined, documented, preserved and/or disposed of in a manner considered proper for diagnosis, study, and advancement of medical knowledge.

The tissue obtained in this procedure may be examined by a pathologist at your providers direction. I understand that I may receive a separate bill from the pathologist or laboratory for this microscopic examination.

Comments:

_____

_____

Date: _____ Time: _____ am/pm

_____	_____	_____
Patient's Printed Name or guardian/next of kin	Signature	Relationship, if other than patient.

Patient's Date of Birth_____

I confirm that this form has been completely reviewed with the patient. The potential risks, side effects, and complications were all discussed. All of the patient's questions have been answered.

_____	_____	_____
Provider Signature	Witness Signature	Date