

**FORM - E**

**INFORMED CONSENT: MOHS MICROGRAPHIC SURGERY**

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

This form is designed to provide you with the necessary information that you will need to make an informed decision on whether or not you wish to have Mohs surgery performed. All of the information provided in this form will be or has been reviewed with you by the physician. If you have any questions, please do not hesitate to ask us. Do not sign this form until you are instructed to do so.

**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.

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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.

11. **TUMOR RECURRENCE:** No skin cancer treatment has a guaranteed 100% cure rate. However, Mohs surgery has been shown to have the highest cure rate for the treatment of skin cancer.

**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 cannot 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, and I hereby consent to Mohs surgery and repair if necessary to be performed by Dr. Clark, Dr. Ingraffea, Dr. Eickstaedt, and/or their associates upon \_\_\_\_\_ (patient). I have identified and confirmed the location(s) of my surgical site(s).

I also consent to the taking of photographs before, during, and after the procedure. I understand that these photographs are important to document and follow my 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 understand that the use of digital devices (video camera, camera, tape recorder, cell phone or any other recording device) to record Mohs Micrographic Surgery or any other medical procedure performed by the physicians and staff of the Cary Skin Center is strictly prohibited.**

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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.

I understand that Cary Skin Center has recommended that a spouse, relative, or friend accompany me to Cary Skin Center and drive me home following my surgery. If I decide to drive myself home, I understand and assume the risk involved.

I further consent that in the event of an emergency and I am transferred from Cary Skin Center to another facility I request that any and all documents pertaining to my care at the receiving facility be sent to Cary Skin Center following my treatment at that facility.

My provider has discussed my procedure and all my questions have been answered. I understand the risks and benefits and I agree to the procedure. I have read the above consent form and received a copy.

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.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Robert E. Clark, MD, PhD or Adam A. Ingraffea, MD or Joshua B. Eickstaedt, MD