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# Progressive Surgical Associates

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## INFORMED CONSENT FOR SKIN LESION OR CYST REMOVAL

It is very important to us that you understand and consent to the treatment your doctor is providing and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

\_\_\_\_\_  
Patient's Initials or Authorized Representative

\_\_\_\_\_  
Date

I, \_\_\_\_\_, hereby authorize Dr. \_\_\_\_\_ and any associates or assistants the doctor deems appropriate, to perform an excision or removal of a skin lesion or cyst.

The doctor has explained to me the potential benefits of the procedure. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well-being and safety.

The doctor has explained to me that there are risks and possible undesirable consequences associated with this procedure including, but not limited to blood loss, transfusion reactions, infection, heart complications, blood clots, loss of or loss of use of body part, other neurological injury, recurrence, scarring, reaction to the local anesthetic if used and/or death. If Lidocaine is used, there should be little or no pain afterwards. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis or other diseases. \_\_\_\_\_  
*initial*

In permitting my doctor to perform the procedure, I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his/her assistants, or his/her designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment. Further, any of these risks or complications may require further surgical intervention during or after the procedure, which I expressly authorize. Even without the occurrence of these listed complications, additional surgeries may be required.

In the unlikely event that one or more of the above inherent complications may occur, my physician or covering physician will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

The reasonable alternative(s) to the procedure have been explained to me. These alternatives include, but are not limited to: continued observation, leaving the lesion or cyst in place (which may or may not be cancerous), electrodesiccation, cryotherapy, and repeated treatments with applied medication (risking incomplete removal and uncertainty of diagnosis).



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## USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

\_\_\_\_\_ Foreign language (specify)

\_\_\_\_\_ Sign language

\_\_\_\_\_ Patient is blind, form read to patient

\_\_\_\_\_ Other (specify) \_\_\_\_\_

Interpretation provided by \_\_\_\_\_  
(Fill in name of Interpreter and Title or Relationship to Patient)

\_\_\_\_\_  
Signature (Individual Providing Assistance)

\_\_\_\_\_/\_\_\_\_\_  
Date Time