Southern Tier Dermatology & Aesthetics
Dr. Colleen Crandell, Dr. Curt Fenkl, Jennifer Fabrizi, PA-C, Yvonne Chesna, FNP-C, Stanley Anderson RPA-C

Consent for Surgical Excision(s) Face, Scalp, Neck, and Head

Patient Name: _____ DOB: _____

Date of procedure: _____

I Authorize Dr. Colleen Crandell or her Associate to perform the following procedure:

_____

This for is designed to provide you with the necessary information that you will need to know regarding your surgery. If you have any questions please do not hesitate to ask.

What are the potential complications and side effects of the 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, in which the physician performing the procedure will give more anesthetic to that area if needed. After the procedure some discomfort will be experienced at the surgical site, but it should only be for a few days thereafter.

2. **INFECTION -** anytime that the skin is injured an infection is possible. The rate of infection is very low. Some patients will be prescribed an antibiotic to prevent infection if the physician feels that it is necessary. If after your procedure you feel that surgical site becomes infected, please contact the office immediately.

3. **BLEEDING -** When you leave the 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, do not peek; keep pressure for the full 20 minutes. If this does not work call the office immediately.

4. **SWELLING -** After surgery you should expect some swelling where your surgery was performed and around the wound as well. You may apply ice to the area if needed.

5. **HEMATOMA -** A hematoma is a collection of coagulated blood under the skin. This results from bleeding that occurs after surgery. If a lump forms under the skin call the 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 surgical site heals. Hypertrophic and keloidal scarring is also possible; this is where the scar becomes raised, red and firm to touch. The cosmetic appearance following a surgery is unpredictable. If you have a history of scarring please inform the physician performing the procedure.

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 there is no unnecessary strain at the surgical site. This is very uncommon, but this may occur if activity is not limited during the healing post op period.

8. **FAILURE OF A FLAP OR SKIN GRAFT -** After your surgery is completed we will need to repair the wound. Some patients are repaired with a flap or skin graft. A flap is when you move skin from an adjacent site to close the defect. A skin graft is when skin is taken from another area of the body and transplanted to repair the defect. Smoking is a documented complication to failure of either of these closures, so we ask that your avoid smoking for a couple of weeks after your procedure.

9. **TEMPORARY OR PERMANENT NERVE DAMAGE -** The primary goal of your procedure is to completely remove the tumor. In order to accomplish this, it is sometimes necessary to damage a nerve, not common, but it sometimes occurs. Nerve damage can be temporary or permanent. Recovery may take up to 1 year. 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 the skin cancer, while preserving the function and appearance of surrounding anatomic structures.

11. **TUMOR RECURRENCE -** No skin cancer treatment has a 100 percent guarantee, but we do forward the taken specimen to our pathologist to determine that all margins are clear and whether further treatment is required.

THE COMPLICATIONS OF SURGERY ARE NOT LIMITED TO THE ABOVE …..

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, advantaged, 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 a referral for additional closure or revision of the procedure site.

_____
Initial

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 surgery to be performed by Dr. Colleen Crandell, Dr Curt Fenkl, and/or their associates upon myself.

I have identified and confirmed the location(s) of my surgical site(s). _____
Initial

Photographs of my procedure will belong to Southern Tier Dermatology, 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 if 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. Crandell, Dr. Fenkl, and/or their associates/assistants from any liability in connection with the use of such photographs.

_____ I ***consent*** to have photographs taken before, during and after the procedure

_____ I ***do not consent*** to have photographs taken before, during and after the procedure

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.

ADDITIONAL COMMENTS: _____
_____
_____

_____ _____
Patient printed name/or guardian/next of kin DOB

_____
Signature

I confirm that the form was completely reviewed with the patient, all potential risks, side effects, and complications, post operative care were all discussed, and all of the patients questions have been answered.

_____ _____
Physicians signature Date

_____
Witness signature

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