BIOPSY: DERMATOLOGY

A biopsy is a medical test involving the removal of cells or tissues for examination and to determine the presence or extent of a disease. Further medical or surgical treatment may be needed when the diagnosis is made.

Patient’s Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of biopsy have been discussed with me and may include but are not limited to:

- Postoperative pain and swelling.
- Postoperative bleeding, which may require further treatment.
- Postoperative infection, requiring antibiotics or additional surgery.
- Reactions to medications, sutures, anesthetics, etc.
- Injury to nerves in the area of the biopsy, which may cause numbness, tingling, or a burning sensation. This usually resolves within a few weeks or months but occasionally may be permanent.
- Possibility of a recurrence of the lesion even though it initially appeared to be completely removed.
- During the course of treatment unforeseen conditions may be observed, which may require extending the biopsy area from what was originally planned. I authorize my doctor to perform these additional procedures as necessary using his/her professional judgment.

I understand and accept that there are complications, including the remote risk of death or serious disability, that exists with any surgical procedure.

I understand that tissue cannot heal without scarring and that how each person scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its ultimate appearance (if applicable).

I understand that the degree of sun damage and patient compliance with postoperative instructions ultimately affect healing.

I am aware that smoking during the pre- and postoperative periods could increase chances of complications (if applicable).

I have informed the physician of all my known allergies.

I have informed the physician of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

I am aware and accept that no guarantees about the results of the procedure have been made.

I have been advised of the probable consequences of declining recommended or alternative therapies.

I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation (if applicable).
Pre- and postoperative photos and/or videos may be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending physician (if applicable).

The physician has answered all of my questions regarding this procedure.

Information for Female Patients:

I have informed my physician about my possible use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate mechanical forms of birth control during the period of my treatment and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ________________, MD, with associates or assistants of his or her choice, to perform the procedure of ______________________ on ____________________ at ______________ on ____________________ (procedure name) (patient name) (facility name). I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time: ____________________________ Relationship to Patient: ____________________________

Print Patient or Legal Representative Name: ____________________________ Witness Signature/Date/Time: ____________________________

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding to the patient or the patient’s legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time: ____________________________

_____ copy given to patient _______ original placed in chart

initial initial