

CONSENT FORM

Patient's Name:

Patient / Guardian:

Date of Birth:

The Dr/NP has explained that I have the following condition:

- ☐ Skin cancer, comprising either Confirmed Suspected
- ☐ Basal Cell Carcinoma (BCC)
- ☐ Squamous Cell Carcinoma (SCC)
- ☐ Melanoma
- ☐ Other

We have discussed the options for treatment and agree that in my case this condition requires removal by surgical excision:

- ☐ Site

and repair of the resulting deficit by means of either:

- ☐ Direct Skin Closure
- ☐ Flap (Type / Detail)
- ☐ Graft (Type / Detail)

I consent to the Dr/NP performing this procedure.

The Dr/NP has explained that this is a routine procedure and has indicated that the following risks and complications are involved in this procedure.

1. General Risks

There is a small risk that I may feel some discomfort during the procedure due to failure of the anaesthetic, but that this will be rectified by further injection of local anaesthetic.

2. Specific Risks

There are small risks of

- (1) Wound Infection (2) Wound Breakdown (3) Graft or Flap Failure (4) Nerve Damage

Each of these events is a recognised complication of excision of skin cancer and deficit repair, however each is unusual.

I understand that I will be left with a scar, and that while the scar should gradually improve over time, there is no guarantee as to the final outcome. In some case there will be contour deficit and pigmentation changes especially with split skin graft.

I understand that while the aim of this surgery is to eradicate all disease and it is the Doctor's intent to do this, surgery may not eradicate all disease and that further treatment may be necessary after the removed specimen has been examined by the pathologist.

In addition, significant risks and complications specific to my individual circumstances have been explained as follows: (eg. Haemorrhage if taking anticoagulants, Facial Nerve Paresis)

- ▶
- ▶
- ▶
- ▶

I acknowledge that the Dr/NP has provided me with verbal information concerning the procedure, the risks and benefits and the available alternative treatments. I acknowledge that the Dr/NP has answered my specific queries and concerns regarding these matters.

I acknowledge that the Dr/NP has not made any guarantee that the procedure will cure my condition.

I understand that if immediate life threatening events happen during the procedure, the Dr/NP will provide treatment as is appropriate to the situation.

I have considered the risks, benefits and the alternatives and I consent to the procedure.

.....
Signature of Patient/Guardian

.....
Print Name

.....
Date

.....
Signature of Dr/NP

.....
Print Name

.....
Date