DPN/WART/SKIN Lesion Removal Consent Form

Patient Name	:	Reshma Siya			Emirates ID	:	784-6478-3648736-8
File No	:	4	DOB	: 1995-05-21	Nationality	:	Other
Gender	:	Female	Doctor's Name	: Doctor Vision	Date	:	2023-12-04

I voluntarily consent to undergo electrocautery or minor surgical removal treatment(s) provided by Doctor Vision

Please initial:

☑ I understand that electrocautery treatment will be one of the most effective procedure available to remove the said lesion whereby electricity is used to heat the needle.

☑ I understand that a soft scab will form over the treated area and will drop off by itself and leave a small scar after cauterization.

☑ I understand that it may require removal by minor surgical procedure and might leave a minimal scarring.

☑ I understand that there are some occasions where a problem may not completely disappear and a recurrence is possible.

☑ I have met with the Doctor who is overseeing my treatment and discussed all treatment options available to me.

☑ I understand no guarantee can be made as to the results of my treatment

☑ I acknowledge that I have been informed about the above procedure and I have been given the opportunity to ask questions and that I have fully understood the contents of this consent form and agree to the risks involved.

I hereby give my consent and authorization voluntarily and release Doctor Vision from any claims, implied or stated that I have or may have in the future with this treatment regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	
Patient Name Reshma Siya Date 2023-12-04	Doctor Name Doctor - Laser (DHA101) Date 2023-12-04