

Skin Surgery Consent Form

Surname

First names

Date of Birth

Hospital Registration no.

NHS no.

Responsible Health professional

Job title

Aims and benefits of procedure — circle those which apply / complete

Diagnosis Treatment for _____

Proposed procedure (include type of procedure / site / repair)

<p><u>Risks for all skin procedures</u></p> <p>Scar - the scar may be lumpy, red or pink, painful, stretched, paler or darker, indented or having a feeling of fullness.</p> <p>Hypertrophic or Keloid scarring - where the scar becomes thick and in some cases wider than the initial incision.</p> <p>Numbness, burning, tingling sensations (usually temporary)</p> <p>Bruising, bleeding, swelling</p> <p>Infection</p> <p>Delayed healing - healing is slower than expected.</p> <p>Allergic reactions - to the local anaesthetic, cleaning solutions or dressings applied. These can be mild local reactions or very rarely can be severe e.g. anaphylaxis.</p> <p>Inconclusive result - in some cases, the procedure may not provide useful information on the diagnosis.</p>	<p><u>Site Specific Risks (tick any which apply)</u></p> <p>Nerve damage: may be temporary or permanent.</p> <ul style="list-style-type: none">Temporal nerve - unable to raise eyebrow and sometimes eyelid droop. <input type="checkbox"/>Marginal mandibular nerve - smile asymmetry / dribbling from one side of the mouth. <input type="checkbox"/>Accessory nerve - Unable to shrug shoulder, prominent shoulder / scapula (winging), shoulder pain. <input type="checkbox"/>Other motor nerve - loss of muscle movement <input type="checkbox"/>Sensory nerve - area of numbness separate or extending beyond the scar site. <input type="checkbox"/> <p>Tendon damage - causing partial or complete loss of muscle function. <input type="checkbox"/></p>
<p><u>Additional risks for skin excisions / when stitches are used (tick any which apply)</u></p> <p>Stitch abscess or granuloma - temporary red, painful bump at the scar site. <input type="checkbox"/></p> <p>Incomplete excision or recurrence - further surgery or other treatment required. <input type="checkbox"/></p> <p>Wound dehiscence - wound re-opening following stitching, resulting in delayed healing. <input type="checkbox"/></p>	<p>Black eye / swelling around the eye - temporary closure of the eye can occur in some cases. <input type="checkbox"/></p> <p>Ectropion - pull on the eyelid from tension of the closure or due to scar retraction—may be temporary or permanent <input type="checkbox"/></p> <p>Eclabium - pull on the lip from tension of the closure or due to scar retraction, may be temporary or permanent <input type="checkbox"/></p> <p>Tear duct injury— may cause excess tearing / irritation of the eye <input type="checkbox"/></p> <p>Nasal valve —one or both nostrils may look narrower or wider. May be temporary. Can make breathing feel blocked or stuffy on this side. <input type="checkbox"/></p> <p>Other (please state) -</p>

Stage 1 consent - Statement of healthcare professional

I have explained the procedure to the patient. I have explained what the procedure is likely to involve, the benefits and risks, available alternative treatments (including no treatment) and discussed any particular concerns of the patient.

Signature

Date

Name (PRINT)

Job title

- Statement of Patient**
- Please read this form which advises of the intended procedure/s and the benefits and risks of the proposed treatment. You consent will be reaffirmed at the time of treatment. You have the right to change your mind at any time.
- ☐ **I agree** to the procedure or course of treatment described on this form.
 - ☐ **I understand** that you cannot guarantee that a particular person will perform the procedure. The person, will, however have the appropriate training and skills.
 - ☐ **I understand** there may be supervised trainee healthcare professionals involved in my treatment or procedure.
 - ☐ **I understand** that any procedure in addition to those on this form will only be carried out if it is necessary.

Patient’s Signature

Date

Name (PRINT)

A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Signature

Date

Name (PRINT)

Stage 2 - confirmation of consent - to be completed by the health professional when the patient attends for the procedure if the patient / parent has signed the form in advance.

I have confirmed the patient / parent has no further questions and wishes the procedure to go ahead.

Signature

Date

Name (PRINT)

Job title

Stage 2 - PATIENT - I confirm I wish to proceed with the treatment, have received all the information I require and reaffirm all the above statements.

Patient’s Signature

Date

Name (PRINT)

Statement of the interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability in a way in which I believe s/he can understand.

Signature

Name (PRINT)

Date