CONSENT FOR SURGICAL PROCEDURE

Although complications are infrequent with cutaneous procedures, the following may occur:

1. Infection- Antibiotics and/or surgical drainage may be required if this occurs.
2. Bleeding- A hematoma or a collection of blood under the skin may occur if there is bleeding. Antibiotics and/or surgical drainage may be required if this occurs.
3. Seroma formation- This is a temporary accumulation of fluid under the skin which may require surgical drainage.
4. Nerve injury- Minor sensory nerves may be damaged resulting in localized numbness or increased sensitivity. This may persist for months but may be permanent. In very rare instances, major nerves may be injured resulting in loss of muscle function.
5. Scarring- Objectionable scarring or pigment changes may occur with any surgical procedure. In addition, skin irregularities may occur such as lumpiness, hardness, and dimpling.
6. Normal temporary side effects may occur. This includes pain, inflammation, bruising, and swelling.

In addition to the above complications, there are general risks inherent in all surgical procedures. Although very rare with cutaneous surgery, these risks include but not limited to: allergic reactions to anesthesia, paralysis, strokes, heart attacks, convulsions, brain damage, or even death. If any of this is to occur, I hereby give my consent to my transfer to a nearby hospital.

I confirm the surgeon and his staff have explained to me the nature, purpose, limitations and possible risks of cutaneous surgery. I understand there is no guarantee of outcome with any medical procedure and acknowledge that no guarantee has been made to me. I was given the opportunity to ask questions and all questions have been answered to my satisfaction.

I consent to the pathological examination or disposal of tissue removed during the procedure. I understand that the pathology lab will bill me separately from Alliance Dermatology and that I am responsible for any charges not covered by my insurance plans.

_____	_____	_____
Patient Name (Print)	Patient Signature (Parent/Guardian if minor)	Date

Tri M. Nguyen, MD_____	_____
Physician Name (Print)	Physician Signature