MINOR SURGERY CONSENT FORM

Patients are only expected to consent to the procedure if they understand:

- Why the procedure is needed
- The type of anesthetic used (checking for any allergies)
- Wound aspects—patients should be made aware that there is a small chance that the wound might get infected and that this may require further treatment
- The final cosmetic results cannot be guaranteed as every patient has a completely different healing process as far as final scar appearance is concerned
- Patients are expected to follow instructions given to care for the wound and avoid unwanted early openings which will result in unwanted cosmetic result and wound infection
- Time for removal of the sutures/stitches (if applicable)

Patient Name: _____ Date of Birth: _____

MRN: _____ Phone: _____

PROCEDURE: _____

Complications may include (but are not limited to):

1. Bleeding
2. Infection
3. Delayed healing
4. Scarring
5. Pain

I, _____, consent to the minor surgical procedure as described to me by my Doctor. I have read and understand the information above and fully understand the reasons for my procedure.

Parent/Patient/Guardian Signature: _____ Date: _____

If minor, Relationship to patient: _____

Physician name (print): _____ Physician Signature: _____