CONSENT FOR MOHS SURGERY AND REPAIR

Patient _____ Date _____

Mohs excision of _____, closure as necessary.

Mohs micrographic surgery is a method of excising skin cancers in layers. The entire edge and undersurface of each layer is then examined under the microscope for the presence of cancer cells. Where further cancer is noted, additional layers are taken until a level free of tumor is reached. By removing tissue only where cancer is known to be present, the technique combines a high cure rate with good preservation of normal skin.

The extent and depth of the tumor determine the number of layers of surgery necessary to remove a skin cancer. There is no way to determine beforehand how many layers will be needed to remove the cancer or how large a defect will result when all the cancer is finally removed. Also, more than one surgical procedure may be necessary to remove large or very invasive tumors, cancer in difficult areas, or to obtain the best cosmetic result.

It is important to emphasize that no cancer surgery has a 100% success rate, this included Mohs surgery as such a cancer may recur after surgery. After the cancer is removed, the wound may be allowed to heal naturally, your doctor may surgically repair the defect, or you will be asked to consult with your primary physician or other specialist for further care.

I understand the following: As with any surgery, Mohs micrographic surgery is associated with possible risks and complications including death. Pain, infection, and bleeding may occur after surgery. Minor, serious or life threatening reactions can occur with the use of anesthetics or with medicines given before, during or after surgery. Nerves controlling muscle movement, sensation, or other functions may be damaged. This damage may be permanent. Also poor healing, skin loss, prolonged pain/discomfort, painful or unattractive scarring, darkening or lightening of the skin, unsatisfactory appearance, blood clots in the circulatory system or the lungs or other organs may occur. The need for additional surgery, impairment of organs such as but not limited to the eyes, or lip function when such areas or their nerves or vascular supply are involved. Finally, that the recovery period either expected or prolonged may result in financial loss to me.

I understand that my physician may discover other or different conditions which may require additional or different procedures other than those contemplated at the onset of surgery. I request and authorize the care team to perform such other procedures which are advisable in their professional judgment.

I certify that I have completed the patient medical history form fully and correctly to the best of my knowledge. I understand that withholding medical information could lead to complications or problems that may have been prevented if that information were known by my physician prior to my treatment/procedure.

I will personally and individually inform every physician that is involved in my procedure about the following even if they do not ask me: ALLERGIES, IMPLANTED DEVICES OR APPARATUS, HISTORY OF USAGE OF PREOPERATIVE ANTIBIOTICS, AND ANY OTHER MEDICAL CONDITION OR INFORMATION THAT I FEEL MAY BE RELEVANT. I understand that failing to do so may lead to a serious or fatal complication.

FEMALE PATIENTS Since anesthetic agents can be harmful to the fetus of a pregnant woman. local, sedative and/or general anesthesia should be avoided during pregnancy whenever possible as should all elective or non-necessary procedures. I HERBY STATE THAT I AM NOT PREGNANT AND ACCEPT THE FULL RESPONSIBILITY OF MAKING THIS DETERMINATION.

I authorize and consent to the taking of photographs before, during and after surgery, and at follow-up visits. I understand that photographs are primarily for medical documentation of my surgery. They may also be used for medical education, lectures, and publication in medical journals. I understand that no identifiable photograph of me will be published without my consent.

I have read and understand the above information and have discussed with my care team the nature of the proposed surgery, the therapeutic alternatives, including leaving the cancer untreated, X-Ray, curettage and electrodessication, cryosurgery, standard excision, interferon, laser, and the potential complications of the procedure. The discomfort of the procedure and the likely presence of a visible scar have been explained. The final appearance of the scar-color (red,white,darker), thick or thin, and size, depends on many factors, including, but not limited to, the size, depth, and location of the cancer and can never be guaranteed.

I agree that I have and will follow the instructions either verbal or written given to me by the care team to the best of my ability before, during, and after the above mentioned treatment(s)/ procedures(s). Further, I will notify the care team if any problems occur following my treatment(s)/ procedure(s).

_____ I certify that I have fully read and understand the above consent, that the explanations therein and that were given to me by the care team answered all my questions. I have no additional questions. I understand that no guarantee is made regarding a specific outcome of the surgery, and I ask that the surgery be performed.

Patient / Guardian Signature _____ Date: _____

Print Patient Name _____

Witness: _____

Physician Signature _____

William D. Tutrone, MD