Informed Consent for Mohs or Excisional Surgery & Closure

I hereby authorize Dr. ____________________ to perform the following surgical procedure:
Excisional Surgery and closure as necessary on my ___________________________ or
Mohs Surgery and closure as necessary on my _____________________________.

The nature and purpose of the procedure, as well as the therapeutic alternatives, risks and
benefits have been explained to me.

Benefits: The Mohs procedure offers a high cure rate, accurate margin evaluation, tissue
conservation, the coordination of surgery with pathology, and the safety of local anesthesia.

Risks: Scar, reduced sensation, pain, infection, bleeding and adverse reaction to medication.
• Scar: all human beings heal by permanent scar formation.
• Scar tissue is red for weeks to months (and may persist for longer) and then
usually fades to white, a mature scar.
• Scars overlying active muscle areas tend to widen (stretch) with time. This may
not always be prevented.
• Scars can heal “thick” (keloid or hypertrophic) or can heal “thin” (atrophy); a
process that is dependent, in part, on their location and the healing process.
• The final appearance of a scar depends on many factors. Chances for a good
result can be estimated but can NEVER BE GUARANTEED.
• A change in feeling (sensation) often occurs around a scar. In some areas of the
body, there is also a risk of motor nerve damage. If the tumor involves or impinges
on a nerve, it may be necessary to cut the nerve. This type of damage may be
permanent.
• Pain can occur during the procedure or in the post-operative period.
• Infection can occur following the surgery or in the post-operative period.
• Bleeding can occur after surgery or in the post-operative period.
• Insignificant, serious or life threatening reactions may occur with any medicine.
  • Anesthesia for your surgery: _______________________
  • Antibiotics for your surgery (if needed):______________________

Alternatives: X-ray, ED&C, Cryosurgery, standard excision, Interferon, Laser, or Mohs
excision.

I understand that during the course of the procedure unforeseen conditions may arise that
necessitate procedures different from or in addition to those contemplated. I consent to the
performance of additional emergency operations and procedures that the above named
physician may consider necessary.
I understand that any tissue that is removed may be examined and retained by MKMG for medical, scientific, or educational purposes. I consent to the disposal of these tissues by MKMG in accordance with customary practice.

I understand that sometimes more than one surgical procedure is necessary to remove a large lesion, a lesion in a difficult area, or to obtain the best possible repair of the surgical wound.

I understand that the final defect cannot be predicted and, therefore, the type of closure that will be required is unknown and may even necessitate a delayed closure, staged repair, repair by another physician or secondary intention healing.

I understand that the practice of medicine and surgery is not an exact science and that well meaning practitioners cannot guarantee results.

I have been candid in revealing any condition that may have bearing on this procedure.

I confirm that I have read, discussed, and fully understand the above statements. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction.

Photographic Release Statement:

I authorize and consent to the taking of a series of photographs before, during, and after surgery and at follow-up visits. I understand that the 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.

Check one: ☐ Yes ☐ No

_________________________________________   ________________
Patient/Relative/Guardian Signature       Date

Relationship (if signed by person other than patient)

_________________________________________   ________________
Witness Signature       Date

Printed Witness Name