VALERIE G. DAVIS, M.D.

504 SOUTH ORANGE STREET
NEW SMYRNA BEACH, FL 32168
386-423-2218

FELLOW OF THE AMERICAN ACADEMY OF DERMATOLOGIC SURGERY

OPERATIVE REQUEST AND CONSENT FORM
SKIN GROWTH EXCISION

I, ______________________________, whose signature appears at the bottom of this form do hereby request and give my informed consent to Dr. Valerie G. Davis to perform the following operative procedures:

1. Local anesthesia with Xylocaine, and/or Marcaine, and Epinephrine (The law requires that you acknowledge that a choice of anesthesia provider exists). I consent to the administration of anesthesia by the provider of Dr. Davis' choosing.
2. Surgically cutting out the skin growth from the ____________________________________.
3. Closing the skin back together with a ______________________________________ repair.

Additional details: ____

____

The length of the incision will be approximately ____________________. The incision may be longer or the repair different if unforeseen complications develop during the procedure. I have seen diagrams of a similar procedure.

I have been informed, to my satisfaction why the procedure is necessary, the risks to my health if the condition remains untreated and what the procedure will entail.

I have read and reviewed with Dr. Davis the details of the procedure as outlined in the patient information sheet entitled **EXCISIONAL SURGERY.** I understand this information and have no unanswered questions. I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner.

I understand that this will be a surgical procedure and that it will be performed under local anesthesia, most likely Xylocaine 2% and/or Marcaine 0.5% with or without epinephrine, and that I have previously had no allergy to these agents.

I give permission to my doctor to do this procedure in the manner which she considers to be best for me. She has my permission to close the wound in the manner which she believes will give the best therapeutic, functional, and cosmetic result. Stitches, staples, or surgical glue may be used to repair the wound.

I have been made aware that there are certain **risks** inherent to the performing of any surgical procedure such as loss of blood, infection, reactions to anesthesia, and the formation of thick or otherwise objectionable scars.

Possible risks include:

-Bleeding under the stitches sometimes requires the wound to be re-opened, drained, cauterized, and re-stitched
-Temporary or permanent numbness of the skin may result from surgery
-Temporary or permanent disfigurement of facial appearance
-Temporary or permanent nerve damage with impairment of facial movement or other muscle movement.
-Infection will require antibiotics, possible opening of the wound for drainage, and possible insertion of drains.
-Thick scars may require monthly cortisone injections to flatten them
-Objectionable scars may require a second surgical procedure to improve them. Some objectional scars cannot be repaired.
-Hospitalization and possible death from complications.
-Complete loss of a body part
-If the laboratory exam of the removed tissue shows a cancer, a second surgical procedure may may be required.
-Additional risks of the particular procedure:
____
____
____

I acknowledge that the doctor has made no promises to me, oral or written, in connection with the operation. I recognize that every surgical procedure involves uncertainty and that no result can ever be guaranteed.

I give my permission to have any tissue removed during the procedure to be sent for laboratory examination by a pathologist.

I give my consent to have photograph(s) taken of the operative site before, during and after the performance of the procedure. I realize that this photograph(s) is part of my medical record and therefore confidential in nature.

I release the doctor from any responsibility which takes place as a natural complication of the procedure. I also realize that it is my responsibility to keep post-operative appointments. If I feel that any problems exist such as bleeding or infection, or if I have any doubts, I am to contact the doctor as soon as possible.

By signing below, I acknowledge I have read this form, and have had it explained to me. I understand this form, and I voluntarily consent to allow Dr. Davis to perform the procedures described above.

__________________________________ ________________________
Signature of Patient **Date**

__________________________________ ________________________
Printed Name of Patient **Witness**

________________________________ ________________________
Valerie G. Davis, M.D. **Date**

This office is regulated pursuant to the rules of the Florida Board of Medicine as set forth in Chapter 64B8, Florida Administrative Code.