

Dermatology of Seattle
13610 First Avenue South, Seattle, WA 98168
206-248-5020 – 206-244-8425 (fax)

SURGICAL CONSENT

Name: _____

Date: ____/____/____

- I am scheduled to have Excision of Cancer/Cyst/Mole or Other Growth to be performed by Dr. Levy and such assistants may be selected by him.
- I have been informed to my satisfaction of the mentioned procedure(s), why it is necessary, the risk to my health if the condition remains untreated and what the procedure will entail.
- I hereby give my permission for the administration of medication and pre-surgery instructions have been explained to me, as well as the procedure to be performed. Admission to a hospital of choice by the performing surgeon, if in his/her opinion such admission would be advisable.
- I also understand that during the course of the operation, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those planned. I authorize the above named surgeon or his designee(s) to perform such surgical procedures as are necessary.
- I have been made aware that there are certain risks inherent to the performing of any surgical procedure such as: loss of blood, infection, swelling, hematoma, pain, tingling, numbness or other nerve sensations including nerve damage, reactions to anesthesia and formation of thick or otherwise objectionable scars. Additionally, 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.
- Following surgery, I will/will not have a responsible adult drive me home as per previous arrangements. I realize that impairment of full mental alertness may persist for several hours following the administration of anesthesia, and I will avoid making decisions, taking part in activities which depend upon full concentration of judgment during that period.
- I release that doctor from any responsibility that takes place as a natural complication of the procedure. I also realize that impairment of full mental alertness may persist for several hours following the administration of sedatives or anesthesia.
- I, the undersigned, consent to the taking of photographs of me during the diagnostic and/or treatment sessions, operations and/or other surgical or medical procedures.
- I consent to the disposal of any tissue which is removed in accordance with accustomed practice and procedure. I give my permission to have any tissue removed during the procedure sent for histologic examination.

Patient/Guardian Signature:

_____/_____/_____
Date

Witness Signature

_____/_____/_____
Date

Physician Signature

_____/_____/_____
Date