**Dermatology Consultants of Marin, INC**

**5000 Civic Center Drive**

**San Rafael, CA 94903**

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**Informed Consent for surgical procedure**

 1. I consent to the performance of the following procedure: Excision Curettage and Desiccation Shave Removal Other The purpose of this operation is to: Remove skin cancer Remove a suspicious lesion for biopsy (evaluation) Remove a growth for cosmetic reasons Other And will be performed by my physician and his/her medical assistant(s).

2. The nature and the purpose of the procedure, the benefits, and risks, the possibilities of complications, and the alternatives to this procedure and their risks and benefits, have been explained to me.

3. It has been explained to me that a satisfactory result is expected, but that the following are some of the complications that could or may occur: bleeding; infection; damage to adjacent tissue or organs including nerves, with resultant loss of sensation (numbness) loss of movement; swelling; pain; suture reaction; delayed healing; medication reaction; recurrence; need for additional operations; and in rare instances, paralysis or death. Additional risk.

4. There will be a scar. In some cases, a keloid scar (a red, raised itchy scar) may develop. Some scars stretch and become wider with time. The estimated length and character of scarring, which is anticipated, has been described to me. I understand that scars are permanent.

5. No guarantee or assurance has been given by anyone about the results that may be obtained.

6. I consent to administration of such anesthetics as may be considered necessary or advisable for this procedure.

7. I do have not have allergies

8. I was invited and encouraged to ask any questions I may have.

All of my questions have been answered to my satisfaction. I have read and understand the content of this form, and will be given a copy if I request it.

Witness Signature Patient / Agent / Guardian Signature