ÖZEL Anadolu Hastanesi
ESKİŞEHİR

Surgical Consent for Excisions of Lesions/Lymph Node Biopsy

Diagnosis:

- You have been diagnosed with skin lesions and/or an abnormal lymph node. Lymph nodes vary in size from the size of a pinhead to the size of an olive. They act as filters keeping bacteria from entering the blood stream.

Name of Procedure/Treatment:

- Excision of skin lesion(s) and/or lymph node biopsy. A biopsy will remove all or part of the lymph node.

Nature and purpose of proposed treatment:

- An incision is made around the growth and it is removed. The area will then be closed using stitches or staples and a dressing or bandage will be applied.

Risks common to all surgical procedures:

- Injury to a blood vessel or excessive bleeding. This may require a blood transfusion.
- Infection, which may require the use of antibiotics. In rare cases, another surgical procedure may be necessary to remove the infection.
- Complications with anesthesia. This may include nausea, vomiting, or in rare cases, death.
- Tobacco use, excessive alcohol use and obesity can increase the risk of any surgical procedure or general anesthetic. Any of these factors may substantially affect healing and can result in an increase of major complications including pneumonia, wound infection, blood clots in the legs and lungs, or death.

Risks and possible complications of the proposed treatment:

- Scarring after surgery at the incision site
- An infection, which may require you to take antibiotics. Another surgical procedure may be needed.
- Recurrence of disease which may require repeated surgery
- Possible injury to underlying structures such as a nerve or blood vessel
- Incomplete removal requiring re-excision (repeated surgery) of a lesion

Risks or complications of the proposed treatment that is specific and unique to the patient:

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Alternative Treatments:

- Observation of the area
- Surgical excision of the mass

Prognosis if the proposed treatment is NOT accepted:

- Continuing Pain
- Infection
- Bleeding
- Unknown diagnosis of cancer
- Spread of Cancer

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CONSENT

Consent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in this Consent Form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document and all applicable blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked by me in writing.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in this consent form, including risks or alternatives, and acknowledge that my questions have been answered to my satisfaction.

_____ _____

Signature of Patient Date/Time Signature of Patient Representative Date/Time

_____ _____

Signature of Witness Date/Time Print Representative's Name

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Relationship to Patient