Colorado Dermatology Institute

Excision Consent

Please read the below and ask any questions you have before signing the form and before the procedure begins.

General Information:

You have a lesion which has some concerning features. While you have not been diagnosed with a skin cancer, we feel it is prudent to have the lesion excised and sent for pathologic evaluation for further examination for abnormal features and to ensure complete removal of this lesion.

I understand that I need to have routine full body skin exams, at least yearly, by a Dermatologist. I understand I should perform monthly self-skin exams of my skin in order to help spot concerning lesions early and I should call immediately for an appointment if I find a concerning lesion or if anything on my body is growing, changing, or not healing.

I hereby authorize Colorado Dermatology Institute's providers/residents/associates/assistants to perform the procedure(s). The procedure, its purpose, as well as alternative therapeutic options have been explained to me (including the option to not having any treatment performed at all). Although every attempt will be made to minimize the chance of complications, I understand that the following complications are possible:

1. Allergic reaction to anesthesia, antibiotics, or bandages.
2. Bleeding from the surgical site.
3. Bruising at or around the surgical site.
4. Scar formation will occur, and on rare occasions unsightly or thickened scars (keloid, hypertrophic, or pink/red scars) can form.
5. Wound infection.
6. Ulcerations, necrosis (tissue death), or dehiscence (separations of the edges of the suture wound).
7. Post-operative discomfort and/or pain.
8. Skin color changes (lightening or darkening), which may be permanent.
9. Recurrence (regrowth) of the lesion at the surgical location or elsewhere in the body.
10. Loss of or decreased sensation (feeling), which may be permanent.
11. In rare instances loss of movement around the surgical site which may be permanent.

I have had the opportunity to speak with the medical/pathology staff at Colorado Dermatology Institute and have been given the link to educational videos the Colorado Dermatology Institute has published. I understand that it is highly encouraged to watch the videos that pertain to my diagnosis and treatment so that I can better understand the diagnosis and proposed treatment. All of my questions have been addressed and I understand the diagnosis and treatment options and recommendations.

I understand it is my responsibility to make sure I take proper care of my treatment site to ensure the best healing. Post-operative instructions are provided to minimize the chance and severity of many of the potential complications. I understand chronic wounds could develop as a result from treatment that might require outside specialties/products/procedures to be consulted or used as appropriate to try to get the wounds to heal. I acknowledge that no guarantee or assurance has been given by anyone as to the end result of the procedure(s), and for excisions performed on minors, the parent or guardian understands that the scar is likely to spread and require cosmetic revision once the minor has stopped growing.

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I understand I will have stitches and it is my responsibility to make myself available in 5-21 days for suture removal. I understand if I cannot make it to Colorado Dermatology Institute it is my responsibility to have the suture removed, at my own cost, at the suggested time.

I also consent to the taking of photographs before, during, and after the procedure. These photographs are important to document and follow your progress after surgery. These photographs will belong to Colorado Dermatology Institute and may be used for research, educational and scientific purposes. I also release Colorado Dermatology Institute and all associates/residents/assistants from any liability in connection with the photographs use.

I understand if my insurance does cover this procedure I will be responsible for any outstanding balance not covered.

I have read and understand this consent form. The nature and purpose of the procedure(s), alternative therapies, and potential risks have been explained to me to my satisfaction. I acknowledge that I have had the opportunity to ask my provider all of my questions regarding this procedure(s) and that they were answered before the procedure(s) began. I attest that I am of sound mind and not under the influence of any mind-altering substances.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____