

**The Skin Surgery Center of Houston
Libbyette E. Wright, M.D.**

Informed Consent for MOHS Surgery

Patient Name: _____ Date: _____ Time: _____

Diagnosis requiring procedure: _____

- _____ I hereby request and authorize Dr. Wright, aided by her assistants, to perform MOHS micrographic & reconstructive surgery on me on or about the _____ day of _____, 20_____ for the purpose of removing skin cancer and reconstructing the resultant defect.
- _____ I also authorize the operating surgeon to perform any other procedures that she may deem necessary or desirable in the attempt to improve the condition(s) stated above or any other unhealthy or unforeseen condition that she may encounter during the operation. I consent to the administration of anesthetics to be applied by or under the direction of Dr. Wright to the use of such anesthetics and medications as deemed advisable in my case.
- _____ I have been advised that this surgery involves external skin incisions which may leave permanent scars, as is the case in all human beings. I understand that scars may take one year or more to fully mature, usually starting out pink to red and usually fading gradually to white in the first 12 months depending on skin tone. I have been advised that, in the first few months after surgery, sunlight tends to darken scars and make them more noticeable. Though most scar lines heal normally, some scars can heal abnormally thick (keloids and hypertrophic scars) or abnormally thin (atrophic scars). How scar lines heal depends on many factors, including but not limited to body location, individual variations in the healing process between patients, and quality of wound care postoperatively. I understand that additional procedures are sometimes necessary in order to obtain the best possible functional and cosmetic result and that these costs may or may not be covered by insurance.
- _____ I agree to follow the instructions given to me by Dr. Wright to the best of my ability before, during, and after the operation, and I will, as soon as possible, notify her of any questionable conditions that may arise.
- _____ I have read and understand the handouts pertinent to my surgery. The nature and usual effects of the proposed operation, the foreseeable risks involved, and alternative methods of treatment have all been explained to me in terms that I understand. **In particular, the risks may include: bleeding, infection, excessive scarring, nerve damage, altered sensation, adverse reaction to medications, and incomplete tumor removal. Practical alternative methods of treatment include: radiation, traditional excision, cryosurgery, electrodesiccation and curettage.**
- _____ I hereby state that the information furnished as part of my comprehensive preoperative evaluation is correct.
- _____ I understand that any price quoted by The Skin Surgery Center of Houston will include physician services only and does not include outside laboratory or facility fees unless otherwise specified.
- _____ I hereby give permission to Dr. Wright or any assistant she may designate to take photographs for diagnostic purposes and the enhancement of the medical record. I agree that these photographs will remain her property. I further authorize her to use such photographs for teaching purposes or to illustrate in scientific papers, books, or lectures of, in her judgment, medical research, education, or science will be benefited by their use.

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- _____ I am aware that the practice of medicine and surgery is not an exact science and, therefore, reputable physicians cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding this operation that I have herein requested and authorized. I have been advised that the goal of the operation I have requested is improvement of the condition and that there is a possibility that imperfection may arise and that results might not live up to my preconceived expectations.
- _____ I have been given an opportunity to ask questions regarding this operation and the matters covered in the preceding paragraphs, and all questions have been answered to my satisfaction.

Patient or Legal Guardian's Signature

Date

Witness Signature