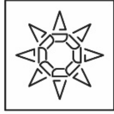

All Dermatology

ARROWHEAD · BILTMORE/ARCADIA · SURPRISE

MOHS SURGERY CONSENT FORM

I, ____ authorize Dr. Lynn Juracek, MD, FACS to perform the following procedure(s):

MOHS Surgery, Stages and Closure on the: ____

I understand the reason for the procedure and any questions I have regarding the procedure have been answered, including a discussion of possible alternatives.

This authorization is given with the understanding that any surgical procedure involves some potential risk. I also understand that the more common risks of any procedure include:

- Infection
- Bleeding
- Nerve injury
- Allergic reaction

I understand that any time the integrity of the skin is interrupted, there is the possibility of abnormal healing with abnormal scarring such as a keloid in spite of good operative technique.

I understand that no guarantee has been made as to the results of the procedure and it may not necessarily result in a cure

I have read and fully understand this consent form.

____   _____________________________________

Witness   Patient/Responsible party

Date:________________________

I have explained the contents of this document to the patient and have answered all of the patient's questions and the patient has been adequately informed. The patient has been consented.

____   ________________

Physician Signature   Date