iD Medical

Consent Form for Minor Surgery

Patient Agreement to Procedure or Treatment

Patient details

Patient's surname/family name ..... Patient's first names.....

Date of Birth..... Male ☐ Female ☐ NHS number .....

Responsible health professional..... Job title.....

Name of proposed procedure under local anaesthetic:

.....

Statement of health professional

I have explained the procedure to the patient, in particular, I have explained:

The intended benefit: Symptoms relief +/- diagnosis.

The significant, unavoidable, or frequently occurring risks

- Allergic reaction.
- Postoperative pain, discomfort, redness and swelling. These may rarely persist long term.
- Bleeding and bruising that may necessitate further treatment.
- Unfavourable scarring (hypertrophic scars and keloid scars) and dyspigmentation (change of skin colour).
- Postoperative infection requiring additional treatment.
- Injury to nerves resulting in numbness or tingling or muscle weakness. This may persist for months, or rarely, permanently.
- Incomplete resolution or recurrence – the lesion may come back.
- Asymmetry and/or deformity.
- Further procedures to address the original complaint or the side effects.

Any extra procedures which may become necessary during the procedure.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

Name (PRINT)..... Job Title.....

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Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe she/he can understand.

Signed..... Date.....
Name (PRINT).....

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask -– we are here to help. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I am aware that in the practice of medicine, unexpected risks or complications not discussed may occur.

I understand that during the course of the proposed procedure, unforeseen conditions may be revealed.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand and accept that the surgeon cannot guarantee the results of the procedure.

I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

Patient's
signature.....Date.....

Name
(PRINT).....

A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Signed.....Date.....

Name (PRINT).....