

«Practice_Name»
«Practice_Phone»
«Practice_Website»

Patient Name:
«Person_First_Middle_Last»

INFORMED CONSENT: HEMATOMA or I&D

This procedure involves making an incision, either with a scalpel or with an electrical device, in order to enable fluid to drain from an area of the body. The procedure is intended to drain a cyst(s), abscess(es), infected tissue or a collection of blood.

Risks include: bleeding, infection, burn injury, pain, scarring, failure to diagnose or cure the underlying condition, persistence or recurrence of the condition, if you were to become symptomatic with a COVID-19 infection during your recovery, it could increase your morbidity/mortality and complication rate.

Benefits may include: achieving a diagnosis (by distinguishing between a cyst and an abscess) and alleviating symptoms such as pain.

Alternatives include: not doing the procedure, trial of medical treatment.

I have been advised of the nature and purpose of the proposed surgical procedure(s), the nature of my condition, alternative types of treatment and the prognosis with vs. without treatment. I have been given ample time to make my decision to undergo this procedure. I have been given the opportunity to consult with other physicians concerning my condition and the treatment if I so desire. I understand that circumstances could arise during the course of treatment which could necessitate the performance of operations and procedures which are different from, or in addition to, those now contemplated. I am aware that the practice of medicine and surgery are not exact sciences and that there are risks and complications associated with this procedure.

I authorize my physician or her assistants to perform additional procedures which, in their judgment, are incidentally necessary to carry out my treatment. I authorize the examination by an authorized individual of any tissue or sample removed from my body as a result of the procedure(s) as well as disposal of same. I understand that I have the right to refuse any medical or surgical procedures or treatment.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND HAVE NO FURTHER QUESTIONS WHICH I NEED ANSWERED PRIOR TO THE PROCEDURE AND THAT ALL THE BLANKS ON THIS FORM HAVE BEEN FILLED IN.

Patient or Person Authorized to sign for Patient: _____ Date: _____

Witness: _____ Date: _____