KNOTT STREET
DERMATOLOGY

MOHS SURGERY CONSENT FORM

Mohs micrographic surgery is a method of removing skin cancers in layers. The entire edge and undersurface of each layer is then examined under the microscope for the presence of cancer cells. Where further cancer is noted, additional layers are taken until a level free of tumor is reached. By removing tissue only where cancer is known to be present, the technique combines a high cure rate with good preservation of normal skin.

The extent and depth of the tumor determine the number of layers of surgery necessary to remove a skin cancer. There is no way to determine beforehand how many layers will be needed to remove the cancer or how large a defect will result when all the cancer is finally removed. Also, more than one surgical procedure may be necessary to remove large or very invasive tumors, cancer in difficult areas, or to obtain the best cosmetic result.

It is important to emphasize that no cancer surgery has a 100% success rate and a cancer may recur even after Mohs surgery. After the cancer is removed, the wound may be allowed to heal naturally, your doctor may surgically repair the defect, or you may be asked to consult with your referring physician or other specialist for further care. There will be a visible scar at the surgical site.

As with any surgery, Mohs micrographic surgery is associated with possible risks and complications. Pain, infection, and bleeding may occur after surgery. Minor, serious, or life-threatening reactions can occur with the use of anesthetics or with medicines given before, during, or after surgery. Nerves controlling muscle movement, sensation, or other functions may be damaged. This damage may be permanent.

I have read the above information and have discussed with my doctor the nature of the proposed surgery, the therapeutic alternatives, and the potential complications of the procedure. The discomfort of the procedure, as well as the presence of a visible scar have been explained. I have no additional questions. I understand that no guarantee is made regarding a specific outcome of the surgery. I request that surgery be performed.

I authorize and consent to the taking of photographs before, during, and after surgery, and at follow-up visits. I understand that photographs are primarily for medical documentation of my surgery. They may also be used for medical education and publication in medical journals. I understand that no identifiable photograph of me will be published without my permission.

PATIENT PRINTED NAME	PATIENT (OR GUARDIAN) SIGNATURE	DATE
PROVIDER NAME	PROVIDER SIGNATURE	DATE