CONSENT FOR LESION/MOLE REMOVAL AND SCAR REVISION

ATLANTIC
Oral Surgery & Facial Reconstruction Centres

I am requesting that **Dr. Bourget** remove a lesion on my head or neck. I realize that most moles, warts and lesions are usually benign, but it is possible that an innocent lesion may prove to be malignant.

- This is my consent for Dr. Bourget and staff to perform Lesion(s) Removal.
- It has been explained to me that Dr. Bourget recommends a biopsy for some lesions that are to be removed.
- Dr. Bourget has explained to me that his removal technique is conservative. More of the lesion can always be taken off, but if the area is over treated, unfavorable scarring could result. As a result of this, it may take several appointments to totally remove the lesion, this method has proven to produce the best outcome. I understand that follow-up treatments may be necessary and additional procedure fees will be charged.
- Lesions may be removed using several modalities including, scalpel excision, laser, Radiowave surgery (Electrocautery) and other means. I understand that although significant scarring is rare, the resulting scar can be unfavorable and require further treatment to improve.
- Complications can result from any method of lesion removal. I understand that although unusual, a permanent scar may be visible. I also understand that the following complications may occur:
  A. Hyperpigmentation (increased pigment)
  B. Hypopigmentation (decreased pigment)
  C. Burns
  D. Blistering, crusting, black and blue marks and discoloration
  E. Lesion may not be completely excised
  F. May be need for revision.
  G. May be keloid scars, neurological and/or functional changes
- I agree to have preoperative and postoperative photos taken for my records as well as for use in medical, scientific, educational and promotional purposes. My name will not be used on any such photographs.
- No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that treatment would be helpful, and that a worsening of my condition could occur sooner without the recommended treatment.

I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made, and that all blanks or statements requiring completion were filled in and any applicable paragraphs were stricken before I signed.

Patient's (or Legal Guardian's) Signature Date:

Witness' Signature Date: