HIGHLINE
DERMATOLOGY
& SKIN CANCER

**Consent for Mohs Micrographic Surgery and Reconstructive Surgery**

Montana state law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team you must enter into the decision-making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1. I hereby authorize Dr. Andrew Shors and/or such associates or assistants as may be selected by said physician to treat/evaluate the following condition(s) which has (have) been explained to me: Mohs micrographic surgery for the treatment of skin cancer. I fully understand what will happen to me during the day on which Dr. Shors will operate on me. Dr. Shors and/or his assistants have explained this procedure in detail.
2. The procedures planned for treatment of my condition(s) have been explained to me by my physician/representative. I understand them to be: Mohs micrographic surgery for the treatment of skin cancer. I have read the handout "Preparing for Mohs Micrographic Surgery", which explains the nature of the procedure and its advantages and disadvantages. I understand its contents. I understand the nature of the procedure and authorize the performance of Mohs micrographic surgery and/or reconstructive surgery.
3. I have been informed of certain risks and complications that can reasonably be anticipated with the procedures described. These include, but are not limited to: bleeding, infection, an unsatisfactory result, nerve damage resulting in decrease in sensation and/or muscle movement, scarring, and recurrence. Sometime, due to the location of certain tumors, there may be possible nerve damage to the local area. This situation is usually temporary but occasionally may be permanent. I understand and have been informed that there are not guarantees or promises as to the success of the procedures performed.
4. I recognize that during the course of the operation, post-operative care, medical treatment, anesthesia, or other procedures, unforeseen conditions may necessitate additional or different procedures than those set forth above. I therefore authorize my above-named physician, and his assistants or designees, to perform such surgical or other procedures as are in the exercise of his professional judgment necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.
5. I have been informed that there are significant risks such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. I acknowledge that no warranty or guarantee has been made to me as to result or cure.
6. Any tissues or parts surgically removed may be disposed of or utilized for educational or research purposes by the hospital or physician in accordance with customary practice.
7. I consent to the photographing of the procedure including appropriate portions of my body for medical, scientific, research or educational purposes during and/or immediately after the procedure, as well as on subsequent office visits. Examples of these uses include non-commercial publications such as medical journals, textbooks and teaching presentations. Although every effort will be made to protect my identification, I also understand that I may be identifiable in the photographs.

HIGHLINE DERMATOLOGY & SKIN CANCER

I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment, and of any recognized serious possible risks and complications of the proposed treatment and of alternative forms of treatment, including non-treatment.

I certify I have had opportunity to ask questions, I have had all aspects of this medical treatment explained to my satisfaction, and I consent.

I have read and understand this form. I am the patient or the legally authorized person to sign on the patient's behalf.

_____ _____

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON RELATIONSHIP OF LEGALLY RESPONSIBLE PERSON

DATE: _____