



Mid-Florida Dermatology Associates

Dermatology and Dermatological Surgery

ORLANDO
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Orlando, FL 32806
407.299.7333

WATERFORD LAKES
829 Woodbury Rd. # 103
Orlando, FL 32828
407.299.7333

METROWEST
7652 Ashley Park Ct. #305
Orlando, FL 32836
407.299.7333

NEW SMYRNA BEACH
519 North Dixie Freeway
New Smyrna Beach, FL 32168
386.428.2223

OFFICE HOURS BY APPOINTMENT
(407)299-7333

INFORMED CONSENT FOR SURGERY

Operative Procedure:

I _____ /_____/_____
(Patient's Name) (Date of Birth)

hereby request and authorize Dr. Gutierrez aided by any assistants he may designate to perform the above surgery. I also authorize the operating surgeon to perform any other procedures which he may deem necessary or desirable in attempting to improve the condition(s) stated above or any unhealthy or unforeseen conditions that he may encounter during the operation. I consent to the administration of anesthetics and to the use of such anesthetics and medication(s) as may be required in my case. I have been advised that part of this surgery is/may be performed through external incisions in the skin which leave permanent scars whose extent and location have been described and demonstrated to me. I have been advised that scars could take one year or more to mature, the changes ordinarily occur in their appearance having been described to me. I have been informed that the above operation may require transplantation of the tissue from other areas of my body. I agree to follow the instructions given to me to the best of my ability before, during, and after the above-mentioned surgical procedure, and that I will, as soon as possible, notify the surgeon of any questionable complications that may arise. I have received and understandable explanation of the proposed surgery, the effect and nature of the operation(s) to be performed, foreseeable risks involved, and alternate methods or treatment. I have been informed that dermatologic surgery contains the risk of complications, including but not limited to death, scarring, infection, and nerve damage.

I have been informed that if the surgical defect reached a size that requires closure with a flap of graft, then complications particular to these procedures may follow. These complications include but are not limited to failure of the flap of graft with resultant scarring.

Operations that are carried out on the nose carry their own particular complications, such as perforation. If a graft or flap is placed over a surgical defect on the nose, and this graft or flap fails, a perforation may occur.

Also when an operation is being performed on the nose, there is the possibility that the cancer can extend down into the nasal mucosa. If this is the case, a possible perforation may also occur.

If the operation occurs over the ear, excision of a lesion in this area may leave a deforming scar. If the lesion extends down into the cartilage, part of the cartilage may have to be removed. And this may result in deformity of the ear.

I fully understand the above outlined complications. I know that I have the option of consultation with another surgeon for a second opinion and/or performance of the operation. I know that the practice of medicine and surgery is not an exact science, and that therefore, reputable physicians can not guarantee result. I acknowledge that no guarantee or assurance has been made by anyone regarding the operation, which I have herein requested and authorized. In this connection, I have been advised of the goal of the operation and that there is the possibility that imperfections may ensue, and that the results might not live up to my expectations or the goals that have been established. I have been given an opportunity to ask questions I desired regarding the matters stated above, and these questions have been answered to my satisfaction.

Date: _____

SIGNATURE: _____
(Patient or person authorized to give consent for the patient)

WITNESS: _____
(Not a member of the family)