

## CONSENT FOR MOHS MICROGRAPHIC SURGERY

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

1. I hereby request and authorize Dr. Rotter to perform Mohs Micrographic Surgery and reconstructive surgery upon me on or about the \_\_\_\_\_ of \_\_\_\_\_, 20 \_\_\_\_\_.  
The purpose is for removal of a skin cancer on:  
\_\_\_\_\_
2. The effect and nature of the surgery(s) and the anesthesia to be performed, risks involved, as well as possible alternatives including no surgery **have been fully explained to me.** Initial: \_\_\_\_\_
3. I know that the possible risks include infection, bleeding, and failure to remove the lesion. I know that every surgery will leave a **scar**, and that each lesion may **recur.** Initial: \_\_\_\_\_  
\_\_\_\_\_
4. I also authorize Dr. Rotter to perform any other procedures which he may deem necessary or desirable in the course of the surgery(s) in the attempt to improve the outcome or for any unforeseen condition. Initial: \_\_\_\_\_
5. Occasionally, revisions to the scar are necessary and I understand **they are deemed a separate procedure and charge.** Initial: \_\_\_\_\_
6. I know that the practice of medicine and surgery is not an exact science and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee has been made by anyone regarding my surgery(s). Initial: \_\_\_\_\_
7. For lesions on or near the temples there is risk of nerve injury. This would render you unable to raise the eyebrow or tightly close the eye on the involved side of your face. Initial: \_\_\_\_\_
8. For lesions involving the chin or jawline there is a risk of nerve injury. This would result in the inability to move the lower lip on the affected side. Initial: \_\_\_\_\_  
\_\_\_\_\_
9. In the event that one of our health care professionals, workers or employees should be directly exposed to your blood or body fluids (needlestick/splash to mucous membranes), your blood will be drawn and tested for HIV, Hep B, Hep C and Syphilis. Initial: \_\_\_\_\_

Signed: \_\_\_\_\_  
(patient or person authorized to give consent)

Physician Signature: \_\_\_\_\_

Third Party/Translator Signature: \_\_\_\_\_