Custom Family Care

INFORMED CONSENT: INCISION AND DRAINAGE (I & D)

I hereby request and authorize Dr. Pivovarov to perform upon me the procedure: incision and drainage of

_____

This procedure involves making an incision, either with a scalpel or with an electrical device, in order to enable fluid to drain from an area of the body.

The procedure is intended to drain a cyst, abscess, hematoma, or infected tissue.

Risks include: bleeding, infection, burn injury, pain, scarring, and failure to diagnose or cure the underlying condition, persistence or recurrence of the condition. To reduce risk of infection, after the procedure keep the area as clean and dry as possible. If genital incision and drainage is performed, you may also place antibiotic ointment onto cotton balls (not cosmetic puffs) to cover the wounds during urination or bowel movements.

Benefits may include achieving a diagnosis (by distinguishing between a cyst and an abscess) and alleviating symptoms such as pain.

Alternatives include: not doing the procedure, trial of medical treatment, laser incision.

I have been advised of the nature and purpose of the proposed surgical procedure(s), the nature of my condition, alternative types of treatment and the prognosis with vs. without treatment.

I have been given ample time to make my decision to undergo this procedure. I have been given the opportunity to consult with other physicians concerning my condition and the treatment if I so desire.

I understand that circumstances could arise during the course of treatment, which could necessitate the performance of operations, and procedures, which are different from, or in addition to, those now contemplated. I am aware that the practice of medicine and surgery are not exact sciences and that there are risks and complications associated with this procedure. The possibility of severe blood loss, infection, injury, and cardiac arrest could be associated with this procedure. I authorize my physician to perform additional procedures which, in his judgment, are incidentally necessary to carry out my treatment. I consent to the taking of intra-operative photographs.

I authorize the examination by an authorized individual of any tissue or sample removed from my body as a result of the procedure(s) as well as disposal of it.

I understand that I have the right to refuse any medical or surgical procedures or treatment.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND HAVE NO FURTHER QUESTIONS WHICH I NEED ANSWERED PRIOR TO THE PROCEDURE AND THAT ALL THE BLANKS ON THIS FORM HAVE BEEN FILLED IN.

Patient's or Legal Representative's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____