MASSACHUSETTS GENERAL HOSPITAL

PATIENT IDENTIFICATION AREA

PATIENT CONSENT TO PROCEDURE

PATIENT:

UNIT NO:

PROCEDURE:

☐ Right ☐ Left ☐ Both Sides ☐ Not applicable

My doctor has told me and I understand what procedure/surgery I am having done. I understand why I need it, the possible risks (like drug reactions, bleeding, infection, and complications from receiving blood or blood components), and that there is no guarantee of results. My doctor has also explained what might happen to me if I don't have this procedure, other choices I can make instead of having this done, (including choosing no treatment) and what can happen to me if I choose to do something else. I understand that with any procedure, problems could come up that we did not expect. My provider explained to me how he/she prevents infections related to my health. The following additional risks or issues were explained to me:

EXCISION OF SUBCUTANEOUS SKIN TUMOR OR CYST

This procedure involves making an incision over the tumor and removing it in its entirety. Dr. Phitayakorn will perform all critical portions of this procedure. The risks of this procedure include pain, bleeding, and a small chance of another procedure for repeat drainage if mass recurs. There is a small chance of skin infection depending on your natural skin bacteria. You must call Dr. Phitayakorn or one of his associates if you have any questions or concerns. The incision may heal with a Keloid (unsightly scar) depending on your individual wound healing response. Dr. Phitayakorn will try to minimize scarring as much as possible.

If procedural sedation will be used during this procedure to control my pain, I understand that this method of pain control has risks. These risks include difficulty breathing that may require breathing support and decreased blood pressure. The most common side effects are nausea and vomiting. In rare cases, there can be allergic reactions or cardiac arrest (stopping of the heart). Lastly, I may have pain, even after using these medications.

My doctor Roy Phitayakorn, MD and/or his/her associates on the _____ Service will perform my procedure/surgery. I understand that Massachusetts General Hospital (MGH) is a teaching hospital. This means that resident doctors, doctors in a medical fellowship (fellows) and students in medical, nursing and related health care professions receive training here, and may take part in my procedure/surgery. A team of medical professionals will work together to perform my procedure/surgery. My doctor or an attending designee will be present for all the critical parts of the procedure/surgery, although other medical professionals may perform some aspects of the procedure as my doctor or the attending designee deems appropriate.

I understand that this procedure/surgery may have educational or scientific value. The hospital may photograph, videotape, or record my procedure/surgery for educational, research, quality and other healthcare operations purposes. Any information used for these purposes will not identify me.

I understand that blood or other samples removed during this procedure may later be thrown away by MGH. These materials also may be used by MGH, its partners, or affiliates for research, education and other activities that support MGH's mission.

I have had the chance to ask questions about the risks, benefits and alternatives to this procedure/surgery. I am happy with the answers I received. I consent to this procedure/surgery.

Date _____ Time _____ AM/PM _____
Signature (patient/health care agent/guardian/family member) (If patient's consent cannot be obtained, indicate reason above.)

I attest that I discussed all relevant aspects of this procedure/surgery, including the indications, risks, and benefits, as compared with alternative approaches, with the patient, and answered his/her questions.

Date _____ Time _____ AM/PM _____
Signature (Physician/Licensed Practitioner)