

**UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
DEPARTMENT OF DERMATOLOGY
SKIN BIOPSY CONSENT FORM**

Date: _____

INTRODUCTION: Your physician has recommended that you have a skin biopsy for diagnostic purposes. The reason for this biopsy is the following: _____

We ask that you read and sign this form so that we can be sure that you understand the procedure, the risk, the alternatives, and the recuperative process. Please ask questions about anything on this form or about this procedure that you do not understand.

PROCEDURE: A small amount of local anesthetic will be injected through a needle into the area of skin in question. After waiting for the anesthetic to become effective, a portion of the skin in question will be removed. The removal may take place by one of the following ways:

- Shave biopsy by using a scraping instrument or surgical scalpel(knife)
- Punch biopsy by using a special cutting device
- Incisional biopsy by using a surgical scalpel (knife)
- Snip excision by using special scissors

The bleeding will be stopped by either the application of a topical medication or by the insertion of a suture.

RISKS: The specific risks associated with the procedure include but are not limited to: bleeding (which is usually easily stopped), infection (extremely rare and may be treated by antibiotics if necessary), scarring, discoloration of the skin (at the site of the biopsy), delayed wound healing (at the site), discomfort during the healing phase, and/or thickening of the skin at the biopsy site (keloid). Sometimes a repeat biopsy may be necessary.

ALTERNATIVES: In most cases, there are no other effective tests to diagnose certain skin problems without physical removal of a piece of skin. If you are reluctant to have the biopsy, please discuss other options with your physician.

AGREEMENT: The information on this form was explained to me by _____. I understand the information and I have had the opportunity to ask any questions that I might have regarding this procedure, the reasons the procedure is being performed, the potential benefits, the associated potential risks and complications, and the possible alternative forms of treatment. I agree to undergo the procedure, to be performed by _____ and his/her associates, assistants, and appropriate hospital personnel, and accept the risks. I agree that fellows, residents, surgical assistants, and other staff as determined acceptable by my doctor may participate in surgical tasks that are part of the procedure. I also agree to have any other appropriate personnel present for the procedure. Furthermore, I agree to care for the wound site as directed on the instruction sheet that I have been given.

<input type="checkbox"/> Name	<input type="checkbox"/> DOB
<input type="checkbox"/> Correct Patient	<input type="checkbox"/> Correct Site
Signature _____	

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I understand that during this procedure, certain tissue(s), bodily substances and/or fluids may be removed and used, disposed of, or transferred by the University of Pennsylvania Health System for educational and research purposes not specifically related to my treatment. I also understand that this includes removal of any items which may result in commercial value created from research using such specimens.

The University of Pennsylvania Health System routinely suspends the resuscitative aspects of living wills and Do Not Attempt Resuscitation orders during the pre-procedure, procedural and post-procedural period, unless you specifically tell us otherwise. This applies to all invasive and operative procedures.

Signature: _____ Date: _____ Time: _____
Patient

Signature: _____ Date: _____ Time: _____
Authorized Healthcare Professional
obtaining & witnessing patient's signature

Signature: _____ Date: _____ Time: _____
Attending Physician if applicable

To be used if the patient is a minor, unconscious or otherwise lacking decision making capacity.
I, _____, the _____
Name Relationship to patient

of _____, hereby give consent on his/her behalf.
Patient's name

Signature: _____ Date: _____ Time: _____
Legally Authorized Representative

Signature: _____ Date: _____ Time: _____
Authorized Healthcare Professional
obtaining & witnessing representative's signature

Signature: _____ Date: _____ Time: _____
Attending Physician if applicable

Signature: _____ Date: _____ Time: _____
Witness to telephone consent

I refuse to have the procedure performed. I fully understand the risks and have had all of my questions answered.

Signature: _____ Date: _____ Time: _____
(Patient or Legally Authorized Representative)

Signature: _____ Date: _____ Time: _____
(Authorized Healthcare Professional Obtaining and Witnessing Signature)