CENTRAL KANSAS PODIATRY ASSOCIATES
STATE OF THE ART PODIATRIC CARE

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CONSENT FOR CUTANEOUS BIOPSY- PUNCH/SHAVE

PATIENT:_____ DATE:_____ CHART #_____

I hereby authorize Dr. Weaver/Bassi to perform upon me the following surgical procedure: Punch biopsy of skin (1.5, 2.0, 3.0 mm) or Shave biopsy of skin. This is a minimally invasive surgical procedure whereby a small cylinder of skin or a superficial layer of skin is removed under local anesthesia for laboratory analysis. I understand that closure of the biopsy site is typically not indicated; however, may be deemed necessary at the discretion of the doctor. Unlikely, but potential, complications of this procedure include local bleeding, infection, numbness, or prolonged pain.

I consent to the administration of anesthesia under the direction of the above named physician as he deems advisable.

The nature and purpose of this biopsy, the risks/benefits of empiric therapy, the risks of leaving the process in question undiagnosed, and the possibility of procedure-related complications have been fully explained to me by the above named doctor. I acknowledge that no guarantee or assurance has been made to me regarding the results that will be obtained from this procedure.

I certify that I have read and fully understand the above consent to biopsy and the associated explanations given by the above listed doctor.

SIGNATURE OF PATIENT:_____DATE_____

The foregoing consent was read, discussed and signed in my presence and in my opinion, the person(s) so signing did so freely with full knowledge and understanding.

SIGNATURE OF WITNESS:_____DATE_____