

Patient Name: _____ DOB: _____ Patient ID#: _____

Surgical Procedure: _____

Location of Abscess: _____

INFORMED CONSENT FOR REMOVAL OF ABSCESS

WHAT CAUSES THE NEED FOR REMOVAL OF ABSCESS?

There are a variety of conditions which require Removal of Abscess surgery. These include, but are not limited to, foreign bodies, inflammation and infection.

WHAT IS DONE DURING THIS SURGERY?

In removal of abscess, an incision is made in or near the abscess and various surgical techniques may be employed to remove a small amount of tissue for culture and/or diagnosis. The area will be debrided and cleaned and the tissue is reposition and wound is closed.

WHAT ARE THE ALTERNATIVES?

You may decide to live with your condition and its associated symptoms. However, if you have had an infection Dr. Cockerham will recommend you proceed with surgery to prevent spread or even death.

Please initial each of the following to document you have read this carefully.

WHAT YOU SHOULD EXPECT AFTER SURGERY:

Itching for at least one week

Bruising for at least two weeks

Swelling for 2 -3 months

Visible scar for 3 – 6 months

WHAT ARE THE RISKS OF SURGERY?

Bleeding

Infection

Opening of the incision due to broken suture or rubbing

Asymmetric or unbalanced appearance

Scarring requiring injections or revision

Permanent hair loss in the area

Patient Name: _____

DOB: _____

WHAT ARE THE MOST SERIOUS RISKS (RARE BUT POSSIBLE)?

- You may need additional treatment or surgery to treat these complications; the cost of the additional treatment or surgery is NOT included in the fee for this surgery.
- Due to individual differences in anatomy, response to surgery, and wound healing, no guarantees can be made as to your final result.
- For some patients, changes in appearance may lead to anger, anxiety, depression, or other emotional reactions.

I have:

___ Received a copy of this consent

___ Viewed & understand the power point information for this procedure

___ Had all my questions answered

By signing below, I am confirming that Dr. Cockerham has answered all of my questions and that I understand and accept the risks and the costs associated with this surgery and future treatments.

Date _____

Patient Signature _____

Witness Signature _____

Time _____ AM / PM

Surgeon Signature _____, MD

Kimberly P. Cockerham, MD