Consent Form for Minor Operation

I...(date of birth)...............................hereby consent to

the procedure of..which has been explained to me by the Doctor listed below.

I have been informed regarding the treatment and procedure, indication and expected results and possible side effects by the Doctor listed below.

I have had an opportunity to have any questions answered to my satisfaction by the Doctor listed below.

I accept that while every precaution has been taken to prevent complications, and that while complications are rare they can and sometimes do occur. These may include bruising, infection, keloid scarring, delayed healing, hypopigmentation or hyperpigmentation.

I accept responsibility for any complication and thereby absolve the Austin Clinic and any associated persons of any blame resulting there from.

I agree to keep the wound clean and dry and out of the sun to reduce scarring and infection.

Do you have a Pacemaker fitted? YES or NO (please circle one)

Do you have metal implants? YES or NO (please circle one)

Patient Name .... Patient Signature ....

Doctor's name .... Doctor's Signature ....

Date ....

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