First Hill
SURGERY CENTER

Excision or Destruction of Internal or External Anal Condyloma (Warts) Consent Form

Patient Name: _____ **Date of Birth:** _____

Guardian Name (if applicable): _____ **Patient ID:** _____

Washington State Law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1 MY PROCEDURE

I hereby give my consent for Dr. _____ to perform excision or destruction of anal condyloma, upon me. I understand the procedure is to be performed at The First Hill Surgery Center. This has been recommended to me by my physician in order to diagnose and/or treat my condition.

I understand that the procedure or treatment can be described as follows:
Injection of local anesthesia followed by excision or destruction of the lesion or lesions in question

2 MY BENEFITS

Some potential benefits of this procedure include:

- Diagnosis, relief of symptoms, treatment of a condition, prevention of spread or prevention of progression to cancer

While excision or destruction of anal condyloma is often helpful for treatment, not all conditions, diseases or problems can be diagnosed or treated solely by this method

3 MY RISKS

*I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.*

These could include, but may not be limited to the following:

- Incisional pain and swelling; bleeding requiring reoperation or transfusion, infection that could require additional treatment, short or long-term numbness or pain in the surgical site; difficulty with healing; scarring or narrowing of the anus, incontinence, or reinfection or recurrence with need for repeat surgery or other procedures

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

4 TISSUE DISPOSAL/PATHOLOGY

Any tissue or specimen may be disposed of in accordance with accustomed practice; or specimen sent to pathology for evaluation in agreement with my designated healthcare provider.

5 MY CONSENT

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures.**

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required.**

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to continued observation, or alternative method of treatment. These alternative forms of diagnosis and/or treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **excision or destruction of anal condyloma** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature:_____ Date: _____ Time:_____
Patient is unable to consent because _____. I therefore consent for the patient.
Authorized Consenter's Signature: _____ Date: _____ Time:_____
Printed Name: _____ Relationship to Patient: _____

☐ Mark this box if telephone consent

Witness Name:_____
PRINT NAME
Witness Signature: _____ Date: _____ Time: _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: _____
PRINT NAME

Physician Signature: _____ Date: _____ Time:_____