First Hill
SURGERY CENTER

Removal of Perianal Skin Tag or Tags 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 of perianal tags upon me. This has been recommended to me by my physician in order to treat perianal tags and will be performed at the First Hill Surgery Center.

I understand that the procedure or treatment can be described as follows:
If indicated, anesthesia may be utilized. Your physician will discuss this with you and a qualified anesthesiologist will be available at the time of your surgery to review your anesthetic.

Injection of local anesthesia to numb the area followed by excision of the affected area. More than one area may be treated by your physician. Suturing of the area may be utilized to control bleeding and or promote healing. Sometimes adjacent hemorrhoid tissue is removed if associated with the tag or tags.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Reduced symptoms related to the tag or tags, improved hygiene and appearance, decreased risk of recurrent symptoms.

While tag excision is often an effective treatment for tags, not all conditions, diseases or problems can be diagnosed or treated solely by removal.

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:

- Bleeding, both immediate or delayed, possibly requiring re-operation; infection or abscess at the surgical site, possibly requiring further treatment and/or surgery; post-operative pain, both acute and chronic; recurrent tag formation or residual or recurrent hemorrhoid symptoms; injury to the sphincter muscles causing temporary or permanent incontinence; narrowing or scarring of the anal canal leading to stenosis, repeat skin tag formation.

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 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 over the counter medications, and/or other surgical techniques. 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 **perianal tag excision** 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:_____