Don Mehrabi MD FAAD
Board Certified Dermatologist

Shave Removal / Punch Biopsy Procedure Consent

A shave biopsy / removal or a punch biopsy is used to remove a lesion for pathological examination. It will aid in the diagnosis of your lesion and may serve to also treat / remove the lesion. Risks of this procedure include, but are not limited to, the following:

Pain - Some people may feel some pain with this treatment. The pain may be stinging or sharp and may continue after the procedure and throughout the healing process.

Redness – There may be surrounding redness of the area. The redness may be present for days to months.

Swelling – Swelling will be present after the procedure and should likely resolve after 1-2 days.

Scarring – There is a risk of scarring with this procedure at any time during the healing process. The scarring may be discolored and may be permanent.

Hyperpigmentation – Discoloration of the procedure site is expected and may be either hypopigmented (white) or hyperpigmented (dark). ***This discoloration may not resolve.***

Bleeding / Bruising – You may get some bleeding after the procedure. The bleeding may result in bruising of the skin. The immediate bleeding / bruising will darken to purple and purple-yellow and will disappear in one to two weeks.

Scabbing – A scab may be present after a shave removal. The scabbing will disappear during the natural wound healing process of the skin. *Scarring or discoloration may result from any scab formation.*

Infection – An infection of the wound is always possible. Any infection could last seven to ten days and could lead to scarring.

Suture Breakage / Wound Dehiscence – With any punch removal, the sutures may break and the wound may split apart. This may result in enhanced scarring or discoloration.

Consent

I, the undersigned, have read and understand the information contained within this consent form. My signature indicates that I have read and understand the information in the consent. I hereby release the dermatology office and my physician from all liability associated with this procedure. Furthermore, my signature below indicates my consent to the treatment described and my agreement to comply with the requirements placed on me by this consent form.

____
Signature

____
Printed Name

____
Date

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