Rahil Malik MD, Fellow of American College of Obstetrics and Gynecology

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VULVAR BIOPSY CONSENT FORM

Date of Procedure

I Name, DOB _____ request Dr **Malik** to perform upon me the procedure: **biopsy of the vulva, single or multiple biopsies of vulva, destruction of lesion(s).**

Indication: This procedure involves taking small sample(s) from the vulvar skin. First a local anesthetic, sometimes mixed with a medication to help control bleeding, is injected into the vulvar lesion. Next an instrument called a punch biopsy is used to obtain the sample. Pressure will be applied to the biopsy site in addition to silver nitrate to control bleeding. The vulvar biopsy will be sent to pathology for examination. The procedure may be used to diagnose infections, inflammatory, pre-malignant, malignant, or other conditions affecting the genital skin.

Risks include: bleeding, hematoma, infection, mild/moderate discomfort, scarring, failure to diagnose or cure the underlying condition, persistence or recurrence of the condition.
Benefits may include: achieving a diagnosis and/or alleviating symptoms.
Alternatives include: not doing the procedure, trial of medical treatment, laser treatment, electrical excision

I have been advised of the nature and purpose of the proposed surgical procedure(s), the nature of my condition, alternative types of treatment and the prognosis with vs. without treatment. My signature below certifies that:
1. I have read the above authorization and consent and have been provided the opportunity to ask questions.
2. The proposed procedure(s) including their potential benefits and complication or side effects, problems that may occur during recuperation and the likelihood of achieving expected goals have been explained to me.
3. I understand that I have the right to refuse any medical or surgical procedures or treatment.
4. I certify that I have read and fully understand the above consent and have no further questions which I need answered prior to the procedure.

PREGNANCY TEST: **NEGATIVE** ☐ **POSITIVE** ☐ PT INITIALS _____
TUBAL LIGATION ☐ MENOPAUSE ☐

_____ Date of Procedure _____
Patient Signature Date

_____ Date of Procedure _____
Witness signature (Medical Assistant) Date

_____ Date of Procedure _____
Dr **Malik** Signature Date