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

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# Vulvar Abscess Incision and drainage CONSENT FORM

Date of Procedure

I Name, DOB _____ request Dr **Malik** to perform upon me the procedure:
**Incision and drainage of the vulvar abscess, and/or placement of word catheter as needed.**

**Indication**: This procedure involves draining a infected area and placing a catheter to allow continued drainage. First a local anesthetic, sometimes mixed with a medication to help control bleeding, is injected into the vulvar lesion. Next the area is drained and word catheter is sometimes placed to allow continued drainage. Pressure will be applied to the biopsy site in addition to silver nitrate to control bleeding. Importance of office follow up was discussed. The procedure will be used to help with pain, drain infected area and prevent recurrence of infection 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**: pain relief, improvement in symptoms, .
**Alternatives include**: not doing the procedure, trial of medical treatment

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.

Date of Procedure

_____ _____
Patient Signature Date

Date of Procedure

_____ _____
Witness signature (Medical Assistant) Date

Date of Procedure

_____ _____
Dr **Malik** Signature Date