Consent form for Radio Frequency

Name : .....Age : ..... Sex : .....
Address : .....

Telephone Number : .....

I here by authorize Dr ..... to operate on myself with radiofrequency surgery for the treatment of ..... Dr..... ..... has explained the procedure(s), technique and I understand the same. I consent to the use of topical anesthesia or injection xylocaine considered necessary or indicated in the judgment of the surgeon. My Physician / Surgeon has/ have adequately explained to me about the alternative available treatments for this condition, possible outcome, risk involved and possible consequences associated with this procedure / surgery, and also about the prognosis if this procedure / surgery is not done. I have understood that fully.I have been explained about the likely changes following this procedure which includes a raw area which can turn brownish followed by a dark discolouraion which can be treated with topical depigmenting agents.

It has been also explained to me by Dr ..... that during the course of the procedure / surgery, unforeseen condition may be revealed, that may necessitate intervention or an extension of the procedure(s). I therefore, authorize my surgeon, his/her assistants, anesthetist, or his/her designees to perform such procedure(s) if the need arises. I authorize the examination by an authorized pathologist, of the tissue excised during the surgery and/ or disposal of such tissue in accordance with the clinic / hospital policies. I also give full consent to take pre and post operative clinical photographs before, during and after the procedure,. I understand that, this will remain confidential. All my questions have been fully answered to my fullest satisfaction.

I certify that I have read and fully understood the above consent. All the blanks or statements requiring insertion or completion were duly filled in before I signed.

Signature of patient /-

Signature of Doctor /-