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CRYOTHERAPY CONSENT FORM

Date: MR#: Date of Birth

Name of Patient:

Purpose: Cryotherapy is a treatment that uses liquid nitrogen to remove precancers, skin tags, warts, seborrheic keratosis, and skin growths by freezing them. Sometimes it can take multiple treatments before it clears. _____ Initial

Proposed Procedure: Liquid nitrogen is extremely cold. When sprayed on the skin, the top skin layer rapidly freezes. When you leave the clinic, the frozen site will probably be red and swollen, and may sting and itch as it thaws. Expect the site to feel like a bug bite. It may look worse over the next few days before it gets better. Swelling and/or blistering often develop within a day after treatment. Two to three days after the treatment, a scab will probably form which will then take seven to ten days to fall off. _____ Initial

Be aware of the following experiences/risks:

- There will be pain while and after the liquid nitrogen is applied.
- The treated skin may become red and swollen.
- You may develop a blister (common), scar (rare), temporary or permanent (rare) discoloration, or non-healing sores at treatment areas, such as the lower legs.

We recommend that you wash the area with soap and water daily until it heals. Cover the treated area daily with a fresh bandage after washing if this area is to be exposed to dirt, sweat, and/or irritation from clothing or picking. _____ Initial

I authorize the office of Metro Dermatology and its licensed clinical practitioners to perform cryotherapy treatment on my ward or me. My ward or I am aware of and understand the risks involved with the treatment. _____ Initial

Other Acknowledgements and Disclosures: I am able to read and understand English. I have had the opportunity to discuss this procedure with the physician or other professional who is to perform it and have had all of my questions answered to my satisfaction. _____ Initial

I consent to the photographing of the areas involved, for medical, scientific, or educational purposes, provided my/his/her/ identity is not revealed by the pictures or by descriptive texts accompanying them. _____ Initial

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Provider Signature Date

_____ _____
Witness Signature Date