TEXAS DEPARTMENT OF HEALTH
DISCLOSURE AND CONSENT
SKIN BIOPSY FOR HANSEN'S DISEASE CASES OR SUSPECTS

Clinic Name:_____

The information in this consent form is given so you can be better informed about the procedure for which you are consenting. After you are sure that you understand the information which will be given about the procedure and if you agree to have the procedure performed, you must sign this form to indicate that you do understand and consent to the procedure.

A skin biopsy is required to provide the physician with additional information for making an accurate diagnosis and determining your response to treatment as well as drug resistance.

I understand that a skin biopsy is the removal of a small piece of skin (3/16 of an inch, or 4 mm, in diameter) under local anesthesia.

I understand that the removal of this skin is a simple procedure but that I may experience some pain and a very small amount of bleeding for several days after the procedure. A small permanent scar (about 1/8 of an inch in diameter) will probably remain at the site. I understand that, as with any wound caused by puncturing my skin, there is a small chance of infection.

I understand that the specimen (skin) removed will be sent to a laboratory for examination.

I have had the opportunity to ask questions about this procedure, the benefits and risks. These questions have been answered to my satisfaction.

(Check one) I have read the form ❑ or I have had the form read to me ❑ and it has been fully explained to me. All blank lines had been filled in before I signed this consent form.

Based on all the above, I give this informed consent for skin biopsy as recommended.

SIGNATURES

Section I:
Patient's Name _____ Patient's Signature _____
Person authorized to consent (if not patient) _____
Relationship _____ Signature _____ Date _____

Section II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.
Patient's Name _____
Name of person giving consent _____ Signature _____
Relationship to patient _____ Date _____
Address _____ Phone Number _____

Section III: Counselor Signature _____ Date _____