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SCALP BIOPSY CONSENT FORM

Question 1. How long is a scalp biopsy procedure?

A biopsy is a 20 minute procedure that involves putting freezing in the skin (local anesthetics) followed by removal of 3-4 hairs and surrounding skin followed by placing sutures (stitches)

Question 2. What are the side effects?

Side effects do not happen in everyone but include:

A. Mild discomfort and burning when the freezing medicine is injected
B. Some temporary bleeding during the procedure
C. Possibly feeling faint (or actually fainting)
D. Rare reactions to local anesthetics
E. Mild pain and tenderness for up to 2 weeks as the area heals
F. A feeling a tightness in the area
G. Rare infections (1:5000 risk or less)
H. A permanent scar, generally no larger than the size of a pencil eraser.
I. Rare temporary headaches after the procedure.

Question 3. When can I wash my hair?

The area biopsied must be washed everyday for three consecutive days. This can be done with ordinary soap and water. You don't need to shampoo the entire scalp unless you want to. The area however, must be washed for 5 seconds with light application of soapy water. Then rinse with fresh water. A light face cloth is fine.

Question 4. Do I need to apply anything to the stitches?

No, you do not need to apply anything. If you wish, you can apply Vaseline petroleum jelly.

Question 5. Will anyone see the stitches? Will anyone see the scar?

Dr. Donovan will do his best to make the stitches as hidden as possible, but it is possible that the stitch could be seen by another person until they dissolve. Dr. Donovan will do his very best to make the biopsy site as small as possible. Everyone heals with a small scar **and there are no exceptions to this rule**. It is possible that the scar could be noticeable by someone who is examining your hair. It will be extremely small, usually about half the size of a pencil eraser.

Question 6. Who will take out my stitches? When are my results available?

Your stitches are 'dissolvable' and will dissolve in 2 months and possibly sooner. Results are available in 4-6 weeks.

CONSENT FOR BIOPSY PROCEDURE – PG 1 of 2

I, _____, hereby give consent to

Dr Jeff Donovan to perform:

□ one 4mm punch biopsy or □ two 4 mm punch biopsies

on this the _____ day of _____ in the year _____

I understand I am requesting the services of Dr. Jeff Donovan in order to gain a better understanding of the cause of my hair loss or hair condition.

I understand that the biopsy or biopsies are necessary in order to determine with greater certainty the reasons for my hair condition and to predict how the hair condition will progress in the future. I understand that without the biopsy some questions could remain as to the cause of my hair condition. I also understand that the results of the biopsy could come back **completely normal** and I agree to accept this interpretation.

I understand that 1-2 small 4 mm circular biopsy (biopsies) will be obtained under local anesthesia (local freezing) and the area will be sutured (stitched close). I understand that the sutures are non dissolving and will need to be removed in about 14 days.

I understand that the sample removed will be send to a local pathology laboratory for analysis. The pathology department will process my sample and my name and identifying details (name address health card number history) will be see by the pathology doctor and assistants who assist the pathologist.

INTIAL EACH OF THE FOLLOWING

I understand the potential side effects of the scalp biopsy including:

_X_____ A) bleeding during the procedure. Any bleeding will be stopped prior to leaving

_X_____ B) infection (risk is 1:5000 or less)

_X_____ C) a small PERMANENT scar at the site of the biopsy

_X_____ D) minor tenderness after the procedure

_X_____ E) Minor headache after the procedure

_X_____ F) Rarely, I may feel faint if anxious or nervous.

CONSENT FOR BIOPSY PROCEDURE – PG 2 of 2

_X_____ I understand that I am to wash my biopsy area or areas with soap and water for three consecutive days in order to prevent infection. Should I develop fever, pus discharge or excessive pain, I am to contact DR DONOVAN immediately by emailing vancouveroffice@donovanmedical.com.

_X_____ I understand that scalp dermatology can be challenging and the pathologist may state that the biopsy is completely normal. However, helpful information can still be obtained and together with the clinical examination this information will be used to assess the cause of my hair condition.

_X_____ I understand that if I am obtaining a biopsy for legal purposes the return of a normal result could affect my ability to claim damages. I am aware of this and by initialing to the left I agree to proceed.

I have been given the opportunity by Dr Jeff Donovan to ask questions and all of my questions have been answered to my satisfaction. I impose the following limitations on my biopsy:

_____

_____

DATE: _____ TIME: _____ (am or pm)

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Doctor **Date**