SKIN TAG REMOVAL CONSENT FORM

(Using Electrocautery / Radiofrequency / Laser Method)

Patient Name: _____

Age / Gender: _____

Contact No.: _____

Date: _____

1. Procedure Description

Skin tag removal involves the elimination of small benign growths of skin (skin tags) commonly seen on the neck, underarms, eyelids, or groin area. The removal is performed using electrocautery, radiofrequency, or laser under local anesthesia to minimize discomfort.

2. Purpose of Procedure

The procedure is performed for cosmetic reasons or to relieve irritation caused by friction with clothing or jewelry. It does not prevent the formation of new skin tags in the future.

3. Possible Risks and Side Effects

I understand that the following risks and side effects may occur:
- Mild redness, swelling, or burning sensation in the treated area.
- Temporary scab or crust formation.
- Post-inflammatory pigmentation (temporary dark or light patch).
- Rare chance of infection or scarring.
- Rare recurrence of skin tags.

4. Pre & Post Procedure Instructions

Pre-Procedure:

- Inform your doctor if you are on any medications or blood thinners.
- Avoid applying creams, oils, or makeup on the area to be treated on the day of procedure.

Post-Procedure:

- Keep the treated area clean and dry for 24 hours.
- Do not scratch or pick the scab.
- Apply prescribed antibiotic or soothing cream as advised.
- Avoid swimming, steam, or strenuous activity for 2–3 days.
- Use sunscreen on exposed areas after healing to prevent pigmentation.

5. Acknowledgment

I acknowledge that the nature and purpose of the skin tag removal procedure have been explained to me. I understand the expected results, possible risks, and side effects. I am aware that recurrence is possible and that new skin tags may develop over time. I voluntarily consent to undergo this procedure.

6. Consent

Patient Name: _____

Signature: _____ Date: _____

Witness Name: _____

Signature: _____ Date: _____

Doctor's Name & Signature: _____