CONSENT FORM FOR WART REMOVAL
(Using Electrocautery / Radiofrequency / Laser Method)

Clinic Name: _____ Date: _____

Doctor Name: _____

Patient Name: _____

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1. 1. Procedure Description

   Wart removal involves the destruction or removal of skin growths (caused by the human papillomavirus) using electrocautery, radiofrequency, or laser technique. The procedure is performed under local anesthesia to minimize discomfort.

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2. Expected Results
   - The treated wart will form a scab which will fall off naturally within 7–10 days.
   - Complete clearance may require more than one session.
   - Mild redness or pigmentation changes can occur temporarily.

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3. Possible Risks & Side Effects
   I understand that the following may occur:
   - Redness, swelling, mild burning, or tenderness in the treated area.
   - Temporary scab formation or minor bleeding.
   - Post-inflammatory pigmentation (dark or light patches).
   - Rarely, infection or scarring.
   - Recurrence of wart despite complete removal, as the virus may remain dormant in the skin.

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4. Pre & Post Procedure Instructions
   Pre-Procedure:
   - Inform your doctor if you are on any blood thinners or have a bleeding disorder.
   - Avoid applying any creams, oils, or makeup on the treatment area 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 the prescribed ointment or antibiotic cream as advised.
   - Avoid swimming, steam, sauna, or heavy exercise for 2–3 days.

- Use sunscreen on exposed areas to prevent pigmentation.

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5. Acknowledgment

I acknowledge that:

- The nature and purpose of the procedure have been explained to me.
- I understand the risks, benefits, and possible side effects.
- I understand that recurrence of warts is possible even after successful removal.
- I consent voluntarily to undergo wart removal treatment.

Patient Signature: _____ Doctor Signature: _____

Date: _____ Date: _____

Witness (if applicable): _____

Date: _____