



Affix Patient Label

Patient Name:

DOB:

## Informed Consent Skin Biopsy for Diagnosis of Small Fiber Sensory Neuropathy (SFSN)

This information is given to you so that you can make an informed decision about having a **skin biopsy for diagnosis of Small Fiber Sensory Neuropathy**.

### Reason and Purpose of the Procedure:

**Small Fiber Sensory Neuropathy (SFSN)** is a nerve problem that affects your feeling of pain and temperature. You may have the sensation of numbness or tingling (“pins and needles”) or burning or stabbing pain. Your doctor or physician assistant would like to do a skin biopsy. The doctor or physician assistant will look at nerve fibers in your skin to make a diagnosis.

The doctor or physician assistant will numb your skin and take skin samples from 3 different areas on your body (lower leg, upper thigh and lower thigh). The skin samples will be sent to a laboratory for testing. You can expect results in about 2 weeks.

### Benefits of this surgery:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Accurate diagnosis of your condition. This can help your doctor or physician assistant with treatment.

### Risks of Surgery:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- **Bleeding.** Bleeding may occur during or after the biopsy. Tell the doctor if you take blood thinners. These may increase the risk of bleeding.
- **Infection.** Your doctor or physician assistant will clean your skin thoroughly before the procedure. An infection may still happen. You may need antibiotics for this.
- **Pain.** You may feel a stinging sensation when the doctor numbs your skin. This usually lasts about 5 seconds. When the medicine has taken effect, you will not feel the biopsy.
- **Scar formation.** The biopsy site is very small less than 1/8 inch. A scar may form when your skin heals. Follow your doctor’s aftercare instructions to reduce your risk.

### Risks Associated with Smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

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**Risks Associated with Obesity:**

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

**Risks Specific to You:**

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**Alternative Treatments:**

Other choices:

- Do nothing. You may decide not to have the procedure.

**If You Choose Not to Have this Treatment:**

- Your doctor or physician assistant will not be able to diagnose your condition with the same degree of accuracy.

**General Information:**

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected

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DOB: \_\_\_\_\_

**By signing this form I agree:**

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Skin Biopsy of Small Fiber Sensory Neuropathy.**
- I understand that my doctor may ask a partner to do the surgery/procedure.
- I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

**Provider:** This patient may require a type and screen or type and cross prior to surgery. IF so, please obtain consent for blood/product.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Relationship:  Patient       Closest relative (relationship) \_\_\_\_\_       Guardian

**Interpreter's Statement:** I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

*Interpreter (if applicable)***For Provider Use ONLY:**

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Teach Back**

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:

\_\_\_\_ Reason(s) for the treatment/procedure: \_\_\_\_\_

\_\_\_\_ Area(s) of the body that will be affected: \_\_\_\_\_

\_\_\_\_ Benefit(s) of the procedure: \_\_\_\_\_

\_\_\_\_ Risk(s) of the procedure: \_\_\_\_\_

\_\_\_\_ Alternative(s) to the procedure: \_\_\_\_\_

**OR**

\_\_\_\_ Patient elects not to proceed: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

*(patient signature)*

Validated/Witness: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_