

Consent to ENFD

Biopsy Procedures



Practice Name: _____

Patient Name: _____

I approve and direct Dr. _____ to perform a 3mm punch biopsy which will be done with a small amount of local anesthetic for the purpose of obtaining an objective diagnosis of Small Fiber Neuropathy.

The risks, benefits, alternatives and complications of the procedure have been explained to me.

I understand the purpose of the procedure needed for my treatment. I know the practice of medicine and surgery is not an exact science. I know that no guarantee can be made about the outcome.

Risks

I also understand there are general risks with surgery or invasive procedures. These risks are:

- infection
- bleeding
- injury to surrounding structures

These risks have been explained to me.

Benefits

I also know the benefits including: Objective and definitive diagnosis of the source of the pain in my peripheral limbs, which will allow my doctor to appropriately treat my causations.

Signatures

My signature below means that:

- I have read and understand this consent form.
- I have been given all the information I asked for about the procedure and risks.
- All my questions were answered.
- I agree to everything explained above.

Patient's Signature: _____ Date signed: _____