MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1a. (Place 'Y' for YES, 'N' for NO in all applicable boxes)				1b. DESCRIBE
Y	OPERATION OR PROCEDURE		SEDATION	**Cryotherapy of Skin Lesion**
	ANESTHESIA	**N**	TRANSFUSION	**Transfusion not expected**

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language). **See attached Procedure Detail Sheet**

Which is to be performed by or under the direction of _____.

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.
4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.
5. Exceptions to surgery or anesthesia, if any are: None (If "none", so state)
6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which may be necessary to remove.
7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions: **Yes**
   a. The name of the patient and his/her family is not used to identify said pictures.
   b. Said pictures be used only for purposes for medical/dental study or research.
8. I understand that as indicated a Health Care Industry Representatives or other authorized personnel may be present.

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

_____
(Signature of Counseling Physician/Dentist)

10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed:

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Patient)*	*(Date and Time)*

11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) _____

sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Sponsor or Guardian)*	*(Date and Time)*

DETAILS OF PROCEDURE/TREATMENT

(Descriptive information about the specific procedure(s)/treatment(s) being performed)

Procedure/Treatment Description
This procedure involves using liquid nitrogen or other substance to freeze growth(s) on the skin. The growth(s) may be benign, precancerous, or cancerous (malignant). Freezing destroys the cells.

Your doctor may numb your skin with a local anesthetic. This may be given with an injection. A local anesthetic is a drug causing loss of feeling in a small area.

Your doctor may use a cotton applicator to apply the cold substance to your skin. Or, the cold substance may be sprayed onto the affected area. Sometimes your doctor may put a gel on your skin and then use a special tool called a cryoprobe to freeze the tissue. The cold substance will be left on your skin until the lesion is frozen. Your doctor may check the temperature inside your lesion by inserting a needle with a thermometer. The frozen tissue will slowly thaw out. The process of freezing and thawing may be repeated several times. Your doctor will talk to you about this.

When the procedure is done, an antibiotic dressing may be applied to the wound.

Diagnosis
Unwanted, benign, precancerous, or cancerous lesion of the skin.

Benefits of treatment(s) or procedure(s)
This procedure may remove abnormal tissue. It may also improve the appearance of your skin. If the growth is precancerous, removing it may prevent cancer. This procedure may remove cancerous or malignant tissue from the skin. It may prevent cancer from spreading.

Reasonable risk / complications of surgical treatment(s) or procedure(s)
* Bleeding.
* Burning or stinging sensation.
* Darkening or lightening of the skin.
* Fever.
* Hair loss.
* Headaches.
* Pain or redness at the treatment site.
* Peeling, flaking, scabbing, or crusting of skin.
* Red, warm, swollen, tender skin.
* Scarring.
* The procedure may not cure or relieve your condition or symptoms. They may come back and even worsen.
* The results of the procedure may not look or feel the way you or others want it to.
* Your doctor may not be able to locate, treat, or remove the entire diseased area.
* Cancer, if present, may have spread. This may require additional treatment now or later.
* Damage to nerve(s). This may include temporary or permanent pain, numbness, or weakness. This may be discovered during the procedure or later.
* Infection.
* Reaction to local anesthesia or other medicines given during or after the procedure.
* You may need additional tests or treatment.
* If the growth is cancer, it may come back.

Additional Risks Discussed (if applicable):

Alternatives to surgical treatment(s) procedures(s)
* Watching and waiting with your doctor.
* Creams or ointments for the skin.
* Removing the growth surgically or with lasers, heat, chemicals, or electric current.
* You may choose not to have this procedure.

Prognosis if not treatment is received
If you choose not to have this procedure, the abnormal tissue may grow or spread. Symptoms such as pain, itching, or discomfort may continue or get worse. If the abnormal tissue is precancerous, it may develop into cancer. If the tissue is cancerous, cancer may spread. Cancer that spreads may be difficult or impossible to treat later.

Blood Transfusion (if applicable): Transfusion not expected

Name of Interpreter (if applicable):

Procedural Time-Out (Universal Protocol checklist)

Procedure(s) to be performed is: CRYOTHERAPY

1. Preoperative Verification Process, required for all procedures. (Check the appropriate blocks – either performed (Yes), or not applicable/required (N/A)

a.	Patent/parent/legal guardian verbally states 2 identifiers (e.g. name/SSN/birth date)	Yes	(required for all procedures)
b.	Correct name on chart/record/consent/radiographs	Yes	(required for all procedures)
c.	Consent verified for planned procedure completed accurately and signed	Yes	(required for all procedures)
d.	H&P within 30 days and updated within the 24 hours prior to procedure	Yes	N/A
e.	Patient allergies	NKDA	Reviewed and Confirmed
f.	Required blood products/implants/devices/graft material/studies/special equipment	Yes	N/A

2. Site Marking: (Check "Yes", or "N/A" if marking is not required)

a.	Patient/parent/legal guardian verbalizes and points to location of surgery	Yes	N/A	
b.	Correct surgical procedure and surgical site marked	Yes	N/A	Unable to Mark

3. Surgical Pause "Time Out" - Immediately before starting procedure

a.	Correct patient identity verbally verified by staff – use 2 pt identifiers (e.g.(name/SSN/birth date	Yes	(required for all procedures)
b.	Correct side, and site and level marked	Yes	N/A
c.	Any required blood products, implants, devices and/or special equipment is available	Yes	N/A
d.	Correct patient position	Yes	N/A
e.	Labeled diagnostic and radiology images displayed	Yes	N/A
f.	Antibiotic administered	Yes	N/A
g.	Mark is visible after drape – make incision *only* if initials are visible and correct Or provider has specified "Unable to Mark" above	Yes	N/A
h.	All members of the procedure team are in agreement on procedure to be performed or a patient safety Time-Out is called (see table below)	Yes	N/A

• Site is confirmed with patient but unable to mark:	# Critical Steps Reviewed:

• Patient refuses marking
• Premature infant
• Technically/anatomically not able to be marked
• Single midline organ
• Site not predetermined – interventional procedures, spinal analgesia, etc.
• Teeth
  • Review the dental record including the medical history, laboratory findings, appropriate charts, and dental radiographs.
  • Indicate the tooth number(s) or mark the tooth site or surgical site on the diagram of teeth or radiograph to be included as part of the patient record.
  • Correct site verified 2nd time following single tooth isolation
	• Surgeon Review
	  • Critical or unexpected steps
	  • Operative duration
	  • Anticipated blood loss
	• Anesthesia Review
	  • Previous issues with anesthesia or peri-operative bleeding
	  • Airway status
	  • Any patient-specific concerns
	  • FSBG or b-HCG
	• Nursing Review
	  • Sterility confirmation (including indicator results)
	  • Equipment issues or any concerns

Verified by: _____ **Date & Time:** _____

☐ **Exception to time-out documentation above: By checking this block, I certify that I have performed and documented the required time-out procedures, as described above, in another document or format. (This includes either a written or electronic pre-operative nursing form, procedure note, or clinical / progress note, which is readily available for verification.)**

Provider / Assistant signature: _____ **Date & Time:** _____

Register No. Clinic/Ward No.

PATIENT'S INFORMATION: (For typed or written entries give:
Name – Last, First MI, grade, rank, rate, SSN, DOB, and hospital or medical facility)