Consent for Patch/Photopatch Testing

I hereby give my consent and authorize Dr. Jonathan Zippin and Weill Cornell Medical College ("Hospital") and its staff to perform the following procedure ("procedure") upon _____ _____(name of patient). I understand that for patch testing I will have allergens applied to my back for 1-2 days. Expected side effects of this procedure include but are not limited to itching, pain, and skin rash. I understand that for photopatch testing, in addition to the above, I will be treated using an ultraviolet phototherapy lamp unit ("device"). I understand that, as with natural sunlight, use of the device may cause adverse effects, including, but not limited to: premature aging of the skin, skin cancer and skin burns. I understand that I, and all other persons who are in the room, need to wear ultraviolet protective eyewear when the device is being operated, and that failure to do so may result in severe burns and long term injury to the eyes.

Dr. Jonathan Zippin has explained to me, in a way I understand, the following:

1. The nature, purpose and the reasonably foreseeable risks of the procedure, including but not limited to: localized flare of dermatitis and other skin disorders, scarring as a result of strong allergic reactions, inadvertent sensitization to patch materials, mechanical or radiation injury due to improper use of light sources, discomfort at patch test sites and "flares" at previously involved sites, hyperpigmentation, and anaphylaxis on very rare occasions.
2. The alternatives to the procedure; including not performing the procedure, as well as the risks and benefits of the alternatives;
3. That the practice of medicine is not an exact science and the procedure may not result in the intended benefits;
4. That there are risks associated generally with medical procedures and treatments not ordinarily anticipated which can cause adverse consequences to my life or health; and
5. That other practitioners may assist with the procedure(s) as necessary, and may perform important tasks related to the procedure.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the procedure specified above. I further grant permission for the use of such tissues and/or organs as it may be necessary to remove during the procedure for purposes of pathological diagnosis and thereafter for the advancement of medical science and education, and their disposal, at this Hospital or at such other institution as this Hospital may designate.

_____ _____ _____ ___/___/___ ____

(Patient/HealthCare Agent/Guardian/Family Signature) (Printed Name) (Relationship to Patient) (Date) (Time)

By initializing here ☐ I consent to the use of film or recording of the procedure for internal education/performance improvement purposes.

_____ _____ ___/___/___ ____

(Patient/HealthCare Agent Signature) (Printed Name) (Date) (Time)

☐ Mark this box if telephone consent ☐ Mark this box if interpreter was involved

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the procedure, the alternatives, including not performing the procedure, as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

_____ _____

(Signature of Physician / Appropriately Credentialed Practitioner Providing Explanation) (M.D. ID Code)