



Department of Health
Government of Western Australia

**CONSENT FORM
FOR
HARVESTING CULTURED
EPITHELIAL AUTOGRAFT**

Med Rec. No.....
Surname:.....
Forename:
DOB:.....

AFFIX LABEL HERE

PROPOSED TREATMENT

The doctor has explained that I, (*name of patient*)
have a and that **harvesting skin for a
cultured epithelial autograft (CEA)** is proposed:

**This means taking a small amount of the patient's own healthy skin, so it can be grown
in the laboratory to provide a layer of cells to cover a wound.**

RISKS

*These are the commoner risks. There may be other unusual risks that have not been listed
here. Please ask your plastic surgeon if you have any general or specific concerns.*

I understand there are risks associated with any **anaesthetic** (*see separate Anaesthetic
Consent Form*).

I may have side effects from any of the drugs used. The commoner side effects include light-
headedness, nausea, skin rash and constipation.

I understand **debriding & cultured epithelial autograft** has the following **specific risks and
limitations**:

- I will have a small scar where the tissue sample was taken for grafting (donor site).
- Some or all of the graft may fail to 'take' (survive), particularly if the wound becomes infected.
- Once healed, the site will need protection from the sun.

I understand some of the above risks are more likely if I am overweight or has other medical
conditions.

INDIVIDUAL RISKS

I understand the following are possible significant **risks and complications specific to my
individual circumstances**, that I have considered in deciding I will have this operation:

.....
.....
.....

MR CONSENT FORM FOR HARVESTING CULTURED EPITHELIAL AUTOGRAFT

**CONSENT FORM
FOR
HARVESTING CULTURED
EPITHELIAL AUTOGRAFT**

Med Rec. No.....
Surname:.....
Forename:
DOB:.....

AFFIX LABEL HERE

DECLARATION BY PATIENT

- I acknowledge the plastic surgeon has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with the plastic surgeon any significant risks and complications **specific to my individual circumstances** that I have considered in deciding to have this operation.
- I agree to **any other additional procedures** considered necessary in the judgement of my plastic surgeon during this operation.
- I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.
- I understand that a doctor other than the specialist surgeon may perform the procedure.
- I have received a copy of this form to take home with me.
- If any staff member is injured or exposed to my blood or other body fluids then I give my consent to a sample of my blood being collected for the purpose of testing for blood borne disorders, such as Hepatitis B and C and HIV.

Signature of patient **Date**

Name of patient

If the patient is an adult and unable to give consent, a proxy form must be completed and attached

DECLARATION BY DOCTOR

- I declare that I have explained to the patient the nature of the patient's condition, the procedure to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's signature

Doctor's name **Date**
(please print)

INTERPRETER'S DECLARATION - I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor

Interpreter's signature **Date**

Interpreter's name
(please print)