

Authorization for Surgery

Patient: _____

As the patient, you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, BUT IT IS YOUR DECISION WHETHER OR NOT TO UNDERGO SURGERY.

1. I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants to perform upon me the following operation: _____

_____ and if, in his/her discretion, during the course of such operation other or different operative procedures appear advisable, to perform such other or different procedures as they had been specifically authorized by me.

2. The nature and purpose of the operation, possible alternative methods of treatment (including no treatment), the risks involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made about the results that may be obtained.

3. I consent to the administration of anesthesia and to the use of such anesthetics as deemed advisable, with the exception of _____

4. I consent to the administration of radiologic procedures (x-rays), the taking of blood and urine samples for Laboratory testing and such additional services or testing as may be necessary.

5. I consent to the use and transfusion of blood and blood products as deemed necessary and will not hold my doctor responsible for any possible adverse effects as a result of such transfusion.

6. I consent to the disposal of any tissues or parts which may be removed during the surgical procedure.

7. I have informed by doctor of allergies to the following: _____

8. I UNDERSTAND THAT THE USE OF DRUGS, including alcohol, prescribed or otherwise; past and present abuse of alcohol or drugs or the existence of conditions such as allergies to medication, pregnancy, epilepsy, herpes, AIDS, and others not disclosed by me to the doctor or his associates/assistants may affect his/her recommendation as to treatment or alternative forms of treatment and I ASSUME ALL RISKS which may exist as a result of my failure or refusal to disclose such matter prior to treatment. It is understood that this paragraph applies to conditions resulting from having consumed food and drink six hours prior to surgery, other than as prescribed by my doctor.

9. I certify that I have read, or had the form read and explained to me, and that I fully understand its contents. I have been given ample opportunity to ask questions and that my questions have been answered to my satisfaction. All blanks or statements requiring completion were completed and all statements to which I do not approve were stricken before I signed this form.

Signature of patient or legal representative

Witness

If legal representative, relationship to patient

Date

Date

Patient: _____

Information about your podiatric surgery:

Alternative Methods of Treatment May Include (doctor will explain):

- _____ Wide shoes or change in shoe gear
- _____ Periodic care
- _____ Antibiotics
- _____ Padding and strapping
- _____ Orthotic shoe inserts
- _____ Change in occupation

- _____ Injections
- _____ Physical Therapy
- _____ No treatment at all
- _____ Other: _____
- _____ Other: _____
- _____ Other: _____

Possible Complications:

- _____ Infection and/or inflammation of operated areas
- _____ Excessive bleeding
- _____ Allergic reaction to suture or other implanted materials (phlebitis)
- _____ Adverse reaction to anesthesia
- _____ Failure of procedure or reoccurrence of condition
- _____ Swollen toe/stiff toe/shorter toe/elevated toe
- _____ Damage to nerves or vascular structures
- _____ Complex regional pain syndrome
- _____ Loss of implant through degeneration
- _____ Permanent swelling/enlargement of toe, foot or limb
- _____ Brain damage
- _____ Stroke
- _____ Difficulty in walking/wearing shoes/playing sports
- _____ Other: _____

- _____ Delayed or no healing of incisions and/or bones
- _____ Excessive swelling/poor or delayed healing
- _____ Peripheral neurovascular complications (i.e.,
_____ Loss of toe, foot, limb or life
- _____ Worsening of condition/disability
- _____ Transfer lesion/callous
- _____ Significant or chronic pain
- _____ Painful or disfiguring scars
- _____ Fracture or dislocation
- _____ Paralysis/paraplegia/quadriplegia
- _____ Cardiac arrest
- _____ Death
- _____ Altered sensation (i.e., burning, tingling, stinging)
- _____ Other: _____

Signature of patient or legal representative

Witness

If legal representative, relationship to patient

Date

Date