

Consent for Treatment

PERIPHERAL VASCULAR DISEASE/DIABETIC PATIENT

(Note: If surgery is to be performed, this form is to be used in conjunction with a surgery consent form.)

I understand that I have poor circulation and this is a progressive condition. I know that risk of disease or complications are inherent to my condition, with or without professional care and treatment.

I understand that I have the following treatment options:

- _____ 1. No treatment
- _____ 2. Special/wider shoes
- _____ 3. Padding
- _____ 4. Soaks
- _____ 5. Periodic treatment to make me more comfortable
- _____ 6. Antibiotics and/or other medications
- _____ 7. Limit my walking/weight-bearing time
- _____ 8. Change in occupation
- _____ 9. Surgery
- _____ 10. _____

I understand that with any treatment of my condition, including surgery, the following risks are present:

- _____ 1. Infection
- _____ 2. Delayed healing
- _____ 3. Wound deterioration or breakdown
- _____ 4. Additional danger of artery/vein clotting (thrombosis)
- _____ 5. Skin necrosis/skin ulcer
- _____ 6. Loss of toe, foot, limb, or life
- _____ 7. Drug reaction
- _____ 8. _____

These risks are present in all operations/treatment. However, I understand that my poor circulation increases my risk for complications. If I have one or more of these complications, I UNDERSTAND THAT MY SUBSEQUENT CARE AND TREATMENT MAY BE MORE DIFFICULT AND THE OUTCOME MORE UNCERTAIN.

NON-TREATMENT OF MY FOOT PROBLEMS also presents serious risks to me. My foot problems could get worse, and I might have new complications such as infection, skin ulcer/breakdown and loss of toe, foot, limb, or life.

I certify that I know or have been informed that I have a systemic condition (peripheral vascular disease/diabetes) for which I have been advised to see a vascular surgeon or other M.D. I UNDERSTAND AND ACKNOWLEDGE MY PODIATRIST WILL TREAT ONLY MY FOOT (and ankle) CONDITIONS AND WILL NOT TREAT DIRECTLY MY SYSTEMIC CONDITIONS.

My podiatrist has explained the above information and the alternatives/material risks to me, I understand this explanation, and I authorize my podiatrist to treat my foot condition(s).

Patient Signature _____ Date _____

Witness _____ Date _____