

# Consent for Surgery

**Patient:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

You have the right and responsibility to make decisions about your health care. Your doctor can give you information and advice, BUT IT IS YOUR DECISION WHETHER OR NOT TO HAVE SURGERY OR TREATMENT.

1. I give my permission to Dr. \_\_\_\_\_ to perform the following operation/procedure/treatment on me:

\_\_\_\_\_

_____	_____
Site/Location	Side

The purpose of the operation or procedure is to: \_\_\_\_\_

2. I understand that the **potential benefits and outcomes** of the operation/procedure/treatment include, but are not limited to:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. I understand that the **potential risks and complications** of the surgery/procedure/treatment include, but are not limited to [check only those that apply]:

- |   |   |
|---|---|
| <input type="checkbox"/> Infection  | <input type="checkbox"/> Allergic reaction to suture or other implanted materials |
| <input type="checkbox"/> Redness and/or swelling of operated areas          | <input type="checkbox"/> Damage to blood supply/circulation (such as blood clots) |
| <input type="checkbox"/> Poor healing of incisions and/or bones             | <input type="checkbox"/> Damage to nerves (burning, tingling, stinging, numbness) |
| <input type="checkbox"/> Failure of the incisions and/or bones to heal      | <input type="checkbox"/> Loss of implant through degeneration/breakdown           |
| <input type="checkbox"/> Excessive bleeding                                 | <input type="checkbox"/> Loss of toe, foot, limb or life                          |
| <input type="checkbox"/> Operation/procedure/treatment may not work         | <input type="checkbox"/> Permanent swelling/enlargement of toe, foot or leg       |
| <input type="checkbox"/> Condition or pain may come back                    | <input type="checkbox"/> Paralysis/paraplegia/quadriplegia                        |
| <input type="checkbox"/> Condition/disability may get worse                 | <input type="checkbox"/> Brain damage   |
| <input type="checkbox"/> Bad or allergic reaction to anesthesia             | <input type="checkbox"/> More treatment or surgery may be needed                  |
| <input type="checkbox"/> Painful or large scars                             | <input type="checkbox"/> Significant or permanent pain (such as CRPS)             |
| <input type="checkbox"/> Calluses or sores may develop on the foot          | <input type="checkbox"/> Stroke/heart attack/death                                |
| <input type="checkbox"/> Fracture/break or dislocation of a bone            | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Swollen toe/stiff toe/shorter toe/lifted toe       | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Difficulty in walking/wearing shoes/playing sports | <input type="checkbox"/> Other: _____   |

4. **My doctor has discussed other options** to this surgery/procedure/treatment for my condition with me. These include but are not limited to [check only those that apply]:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Wide shoes or change in shoe gear | <input type="checkbox"/> Orthotic shoe inserts | <input type="checkbox"/> No treatment at all |
| <input type="checkbox"/> Periodic care                     | <input type="checkbox"/> Change in job         | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Antibiotics                       | <input type="checkbox"/> Injections            | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Padding and strapping             | <input type="checkbox"/> Physical therapy      | <input type="checkbox"/> Other: _____        |

5. **Serial Procedures** – I understand that I will receive a series of the same treatments over a time period not to exceed \_\_\_\_\_ days. From \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_.

N/A \_\_\_\_\_

6. I understand that other health care providers such as surgical assistants, physician assistants, nurses, and other surgical staff may assist the doctor named above in performing my surgery. A surgical resident(s) may participate in some or all of the surgery. I give my permission for them to do so.

7. I consent to the use of anesthesia, except for \_\_\_\_\_.

8. I consent to the taking of x-rays; blood samples and/or urine samples for laboratory testing; and other tests that may be necessary.

9. I consent to the use and transfusion of blood and blood products if my doctor feels it is necessary. I understand that my doctor will not be responsible for any bad reactions as a result of a transfusion.

10. I consent to the disposal of any tissues or parts which may be taken out during the procedure.

11. I have told my doctor about all my allergies. (LIST ALLERGIES) \_\_\_\_\_

12. I have told my doctor:

- a. About all of the drugs I take, including prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs;
- b. About all of my medical conditions such as allergies, pregnancy, epilepsy, herpes, HIV/AIDS, diabetes, circulation problems, etc. that I am aware of;
- c. If I smoke;
- d. If I use alcohol.

I will accept full responsibility for any problems with my treatment that may result because of my failure or refusal to tell my doctor about these things.

13. I understand that no guarantees or promises have been made to me about the results of this operation/procedure/treatment.

14. I understand that sometimes during surgery, it is discovered that additional surgery may be needed. I give my doctor permission to do additional surgery if he/she feels it is necessary.

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. My questions have been answered to my satisfaction. All blanks or statements that required completion were completed before I signed this form. I drew a line through all statements that I do not approve before I signed this form.

I understand the risks, benefits, and alternatives to the proposed operation, procedure, or treatment. I consent to the operation, procedure, or treatment to be performed. YES \_\_\_\_\_ NO \_\_\_\_\_

\_\_\_\_\_  
*Signature of patient*

\_\_\_\_\_  
*Date/Time*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date/Time*

The patient is unable to consent because: \_\_\_\_\_

Therefore I consent for the patient.

\_\_\_\_\_  
*Legal Representative of the patient*

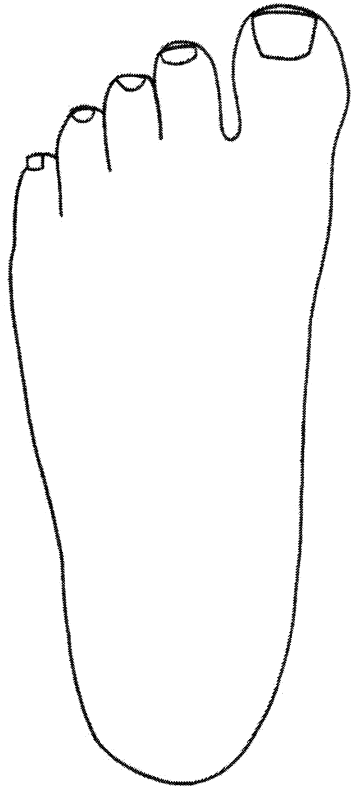
\_\_\_\_\_  
*Date/Time*

\_\_\_\_\_  
*Relationship*

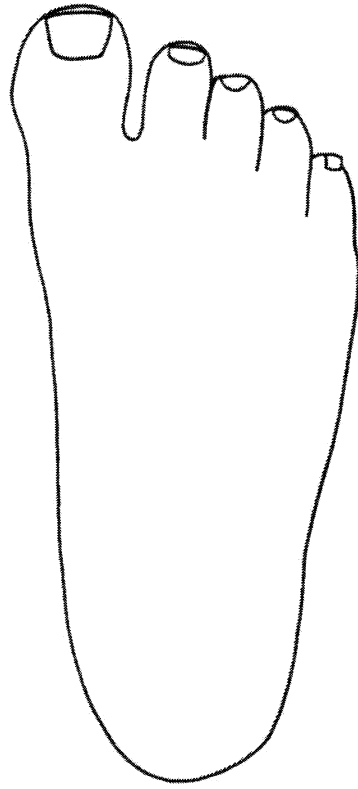
I declare that I have personally explained the above information to the patient or the patient's legal representative.

\_\_\_\_\_  
*Physician*

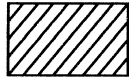
\_\_\_\_\_  
*Date/Time*



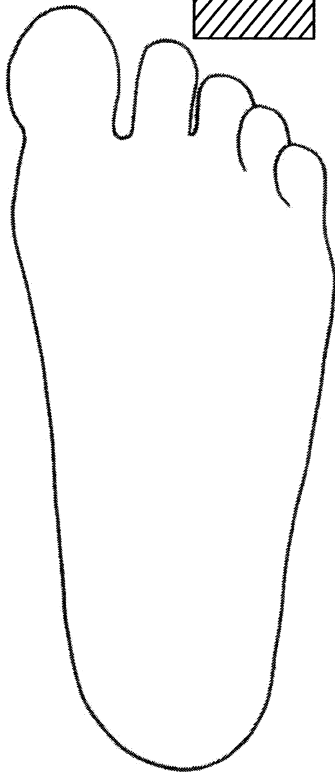
**Left Foot (top)**



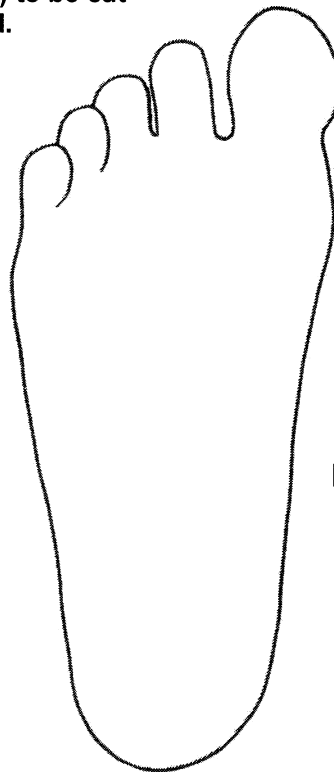
**Right Foot (top)**



**Legend: Area(s) to be cut and/or removed.**



**Left Foot (bottom)**



**Right Foot (bottom)**

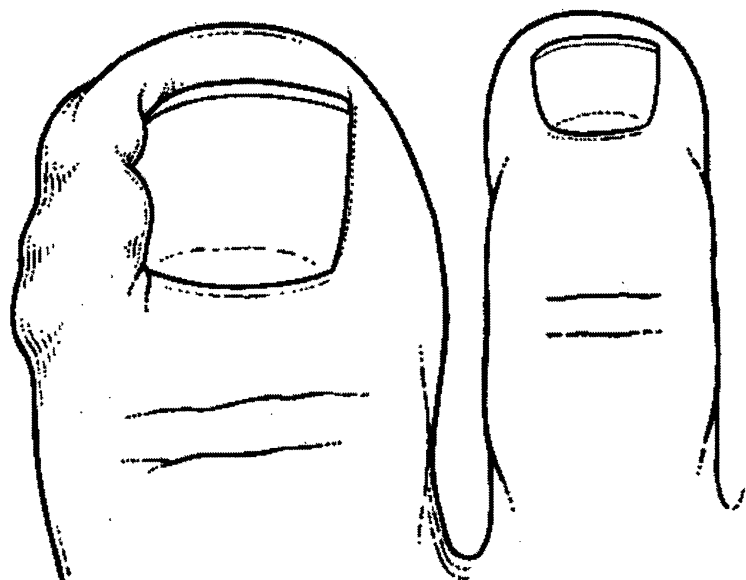
**These diagrams were explained to me and I understand them.**

Patient or Legal Representative Signature: \_\_\_\_\_

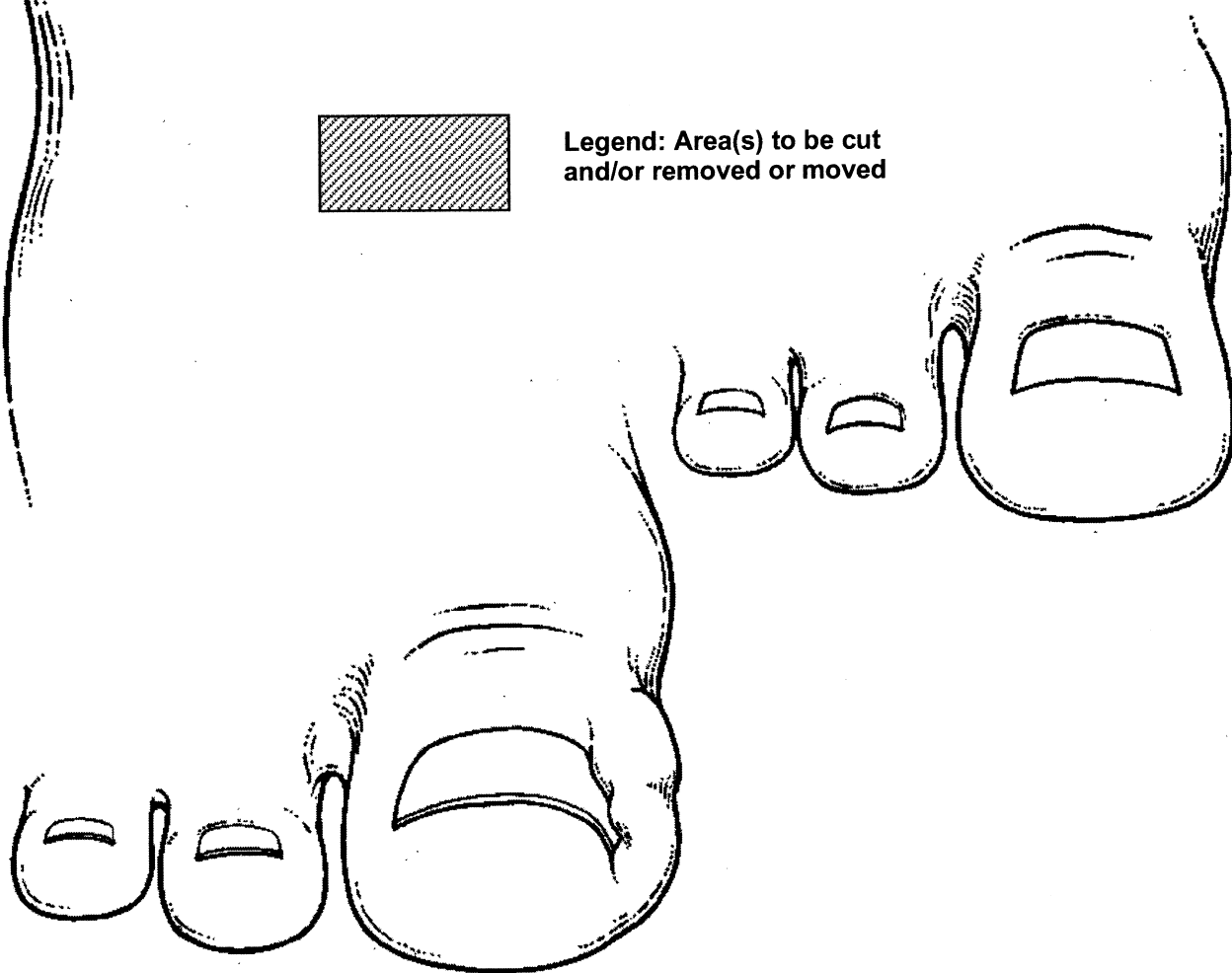
Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Legend: Area(s) to be cut  
and/or removed or moved**



**These diagrams were explained to me and I understand them.**

Patient or Legal Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_