PODIATRIC SURGICAL CONSENT

DUNDEE FOOT & ANKLE CENTER

PAUL POTACH, D.P.M.

31 W. Dundee Road
Wheeling, IL 60090

Telephone: (847) 215-1525
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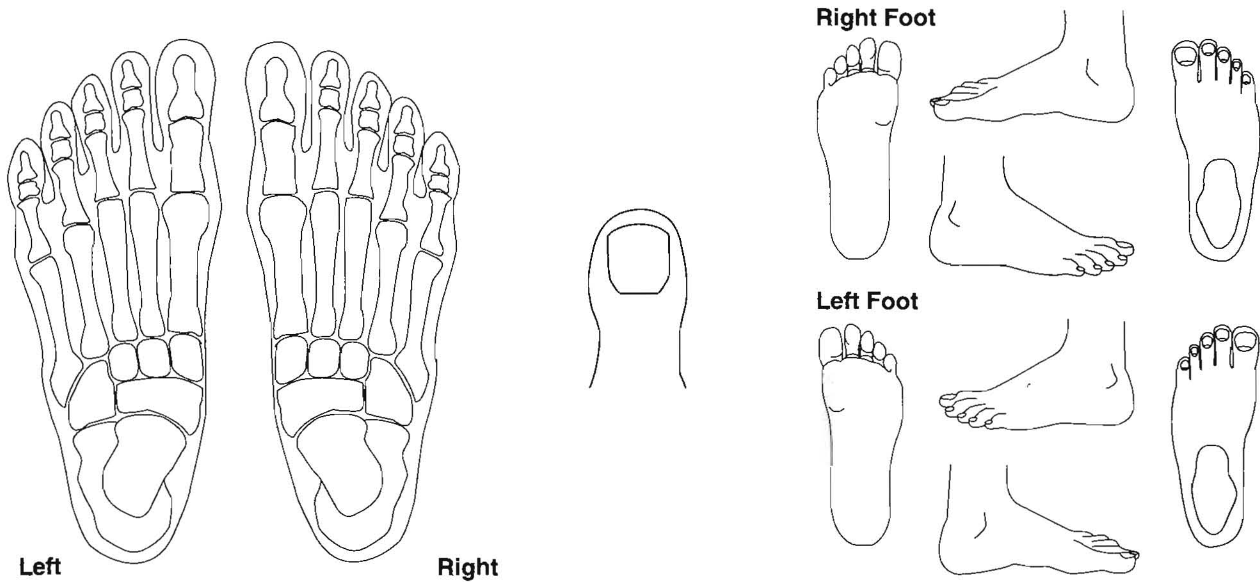
Patient Name______________________________Birthdate__________________ Date ____________

Pre - Operative Diagnosis ____

Proposed Surgery ____



The surgical procedure described above, as well as the risks, benefits, and alternatives, have been thoroughly explained to me. I acknowledge that there can be no guarantee with regard to any medical procedure and no guarantee or assurance has been given by anyone as to the results that may be obtained. I acknowledge that complications could arise, which may or could include:

- ❐ An elevated or longed toe
- ❐ Bleeding (excessive)
- ❐ Delayed healing
- ❐ Disability
- ❐ Extended discomfort
- ❐ Flail (loose) toe
- ❐ Infection
- ❐ Joint stiffness
- ❐ Medication reaction
- ❐ Numbness
- ❐ Phlebitis (blood clot)
- ❐ Recurrence of problem
- ❐ Rejection of a surgical implant
- ❐ Suture reaction
- ❐ Swelling
- ❐ Thick scar
- ❐ Transfer of callous to another area of foot
- ❐ Other ______________________

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I certify that the doctor fully explained the surgical procedure to me, and that I understand the information provided. I have had full opportunity to discuss the surgical procedure and ask questions, and the doctor answered my questions concerning the above. I authorize the above doctor or the doctor's designated assistant to administer such treatment.

____ ______________

Signature of Patient, Parent, Guardian or Personal Representative — Date

____ ______________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

____ ______________

Witness — Date

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