INFORMED PATIENT CONSENT FOR SURGICAL OPERATION, MEDICAL PROCEDURES AND/ OR TREATMENT
ACKNOWLEDGEMENT OF RECEIPT OF MEDICAL INFORMATION

Material Risks Identified by Physician – **Chad Watkins, D.P.M.**

INFORMATION ABOUT THIS DOCUMENT – READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. This document will outline for you: (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the most common risks of the proposed treatment/surgery, as determined by your doctor, (4) reasonable therapeutic alternatives and material risks associated with such alternatives, and (5) risks of no treatment.

You have the right, as a patient, to be informed of your condition and the recommended surgical, medical, or diagnostic procedure to be used. In order, to make an informed decision of whether to undergo the procedure, you need to be aware of the risks and hazards involved. In keeping with the Informed Consent recommendations, you are being asked to sign a confirmation that we have discussed these matters. **Please read the form completely.** As we have already discussed the common problems and risks with you, we wish to inform you as completely as possible about your medical treatment/surgery. Ask questions about anything you do not understand, and we will be pleased to further explain it.

PATIENT NAME: _____

SURGICAL PROCEDURE (S): _____
_____
_____
_____

ADDITIONAL RISKS: Infection, pain, swelling, recurrence, nonresolution of symptoms, loss of sensation, nonhealing, failure of hardware, and scar formation_____

REASONABLE THERAPUETIC ALTERNATIVES TO SURGERY: Surgical and non-surgical options have been discussed and you are aware of the alternative options. Moreover, all questions have been answered for the relative advantages and disadvantages of the recommended operation/medical treatment, *including risks of providing no treatment compared to undergoing surgery for this condition.*

*FURTHERMORE, I understand there are risks in this Operation/Treatment/Special Procedure, but I **DO NOT** wish to know all the details and trust the Doctor's professional ability to carry out the PROPOSED SURGICAL TREATMENT PLAN and/or medical treatment care as deemed appropriate and necessary for my ultimate benefit.*

Material Risks:
All medical or surgical treatments involve risks, listed on the next few pages are those risks associated with this procedure. We believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed treatment. **Please ask your physician if you would like additional information** regarding the nature or consequences, the likelihood of occurrence, or other associated risks **that you might consider significant but may not be listed in this document.**

MUSCULOSKELETAL TREATMENTS AND PROCEDURES

A surgical procedure upon or even a closed manipulation of an extremity, entails risk to a greater or lesser degree to all major systems of that limb. Treatment can result in varying degrees of weakness, deformity, bleeding, infection, disfiguring scars, paralysis (loss of function), pain, numbness, amputation, and/or limitation of joint range of motion.

Anesthesia complications can include heart attack, stroke, brain damage, pneumonia, and death. Furthermore, the expected outcome of the procedure may not be obtained. Other medical therapy or surgical treatments may become necessary to achieve the goals of the original operation.

COMPLICATION LIST FOR ALL ORTHOPEDIC SURGICAL PROCEDURES:

Uncommon Risks -- severe bleeding that requires blood transfusion, scars - sometimes overly thickened to keloid formation, infection, continued or worsened pain, continued or worsened stiffness or deformity, failure of tissue and/or bone healing, hardware/prosthesis implant failure and/or need for early removal or revision, blood clots to legs (i.e. deep vein thrombosis) and/or blood clots to lungs (i.e. pulmonary embolus).

Very Uncommon Risks --artery, vein, nerve, or tendon damage; amputation; paralysis or loss of limb/joint function; need for later implant removal, with or without revision.

ADDITIONAL SPECIFIC RISKS FOR VARIOUS ORTHOPEDIC PROCEDURES:

- **ANKLE/ FOOT SURGERY**: TENDON TRANSFER, OSTEOTOMY and/or JOINT FUSION; ANKLE LIGAMENT RECONSTRUCTION; ANKLE/SUBTALAR JOINT FUSION or TRIPLE ARTHRODESIS; BUNIONECTOMY; HAMMER/CLAW TOE REPAIRS; CYST/TUMOR REMOVAL; PLANTAR FASCIA RELEASE –**Uncommon Risks** -- Loss of motion; return of cyst/tumor; incomplete fusion or loosening of joint parts; need for later implant or metal removal.

ACKNOWLEDGEMENT – AUTHORIZATION AND CONSENT

Dr. Watkins has discussed this material with me. All information regarding the planned procedure has been provided to me. All estimates made as to the prospects of success or the potential occurrence of risks regarding this medical treatment or surgery are made in the best professional judgment of my physician. Furthermore, I understand that no guarantees about any surgery and/or medical treatment outcome can be made and have not been provided.

As such, I impose no specific limitation(s) to my care by the Doctor unless written here:

_____

_____

The nature and possibility of complications cannot always be accurately anticipated. ***Therefore, there is and can be no guarantee (either expressed or implied) as to the ultimate success and results of the medical treatment or surgical procedure(s).*** Nothing further has been said to me and no other informational materials have been given to me. I have not relied upon any other information that is inconsistent with or contrary to the written explanations set forth in this document.

Consent: I hereby authorize, consent thereto and direct Dr. Chad Watkins, along with his associates and/or assistants of his choice, to administer or perform the above-listed medical treatment/surgical procedure described in this consent form, including any additional procedures or services as they may deem necessary or reasonable.

This includes if needed: administration of general or regional anesthesia by or under the direction and supervision of a member of the Department of Anesthesia; the administration of local anesthesia or conscious sedation by the Doctor performing my procedure; administration of x-rays or other radiologic services; laboratory services; insertion of bone graft substitutes or calcium bone void fillers; and the disposal, examination, or preservation for study of any tissue removed during the surgical procedure(s).

_X_ Blood transfusion is **not** generally needed with this procedure.
_X_ If needed, I consent to the use of blood and /or blood products, as deemed necessary.

Specific risks associated with transfusion include: fever, rash, heart failure, acute/chronic liver inflammation/viral infection called Hepatitis B/C that can lead to scarring and/or cirrhosis, other blood infections, AIDS (acquired immune deficiency syndrome), and/or transfusion reactions that may cause kidney failure, anaphylactic shock, anemia or death.

Furthermore, I understand the material as presented above. I have reviewed all information presented in this document and hereby state that I have had the opportunity to ask any questions about the contemplated medical treatment/surgical procedure including risks, benefits, complications, and alternatives. I acknowledge that all of my questions have been answered to my complete satisfaction. ***I have read and understand all information set forth in this document, and all blanks were filled in prior to my signature.***

Signature of Patient or Authorized Person: _____

Printed Name: _____ Date/Time: _____

If patient is a minor or unable to consent -- list age and/or reasons and list relationship.

Witness Certification: The patient was informed and appears to understand all material covered in this Informed Consent document, and signed this form on the indicated date and time noted.

Signature of Witness: _____

Printed Name: _____ Date/Time: _____

Physician Certification: I hereby certify that I have provided and explained the information set forth, herein, and answered all questions of the patient, family members and / or the patient's authorized person, concerning the medical treatment or surgical procedure(s), to the best of my knowledge and ability.

Signature of Physician: _____Date/Time: _____

Chad Watkins, D.P.M

____ To help me understand and consent for my operation, medical treatment, and/or procedure -- this form has been translated into _____ by _____