Informed Consent Form
Serial Foot Care
Consent/Toenail Debridement

I hereby authorize JENNIFER GAULIN NP or her designee to perform the procedure known as foot care/toenail debridement.

I understand that this procedure is not performed under local anesthesia to treat hypertrophic/onychomycotic toenails. The procedure will involve clipping and filing of hypertrophic/onychomycotic toenails causing pain and discomfort. Footcare consent includes permission to assess and treat issues with the toenails and feet. I understand that the practice of medicine is not an exact science, and that no guarantee can be made regarding the outcome of my planned procedure. This consent is good for one year from the current date and will automatically renew one year from now unless canceled by the patient/family.

This consent includes assessment and treatment of hypertrophic/onychomycotic toenail and any conditions that affect the feet and toenails.

The Nurse Practitioner has explained to me that this procedure is generally safe, but that certain risks accompany and this procedure. Risks associated with toenail debridement include the following:

- Minor bleeding
- Pain Associated with the procedure or the healing process
- Infection in the toe or the bones of the foot, or spreading into the body
- Allergic reaction to the procedure instruments
- Rare, unusual reactions, including possible death, from the procedure

I understand that there are alternatives to this procedure, including nail filing. I understand that this alternate procedure may not provide the same benefits as the procedure proposed to me. I understand that I can refuse this procedure.
I understand that unforeseen conditions may alter the planned procedure. I give permission to the nurse practitioner to alter the planned procedure, if necessary, should I need them for the completion of my procedure.
I have read this form and other information given to me by the nurse practitioner. I have had my questions answered to my satisfaction and give consent for the pairing of callous/corn(s).

Patient Name _____ Witness_____

Signature _____ Date: _____