Dr. Fabio D’Angelo

CONSENT TO OPERATION, ANESTHETICS, AND OTHER PROCEDURES

PATIENT	**DATE OF SURGERY**
X-------------------------------	X---------------------

1. I hereby request and authorize Dr. D’Angelo F. and/or such associates and assistants as may participate with him, to treat the condition(s) which I understand to be:

   The procedure or procedures necessary to remedy or treat my condition(s) I understand to be:

   If in the preparation for, during, or following the procedure contemplated above other conditions are discovered which in the best judgment of the doctor make a change or an extension of the originally intended procedures necessary or advisable, I authorize and request that the above named doctors, his associates, and assistants perform such extended or revised procedure or procedures.

2. I acknowledge that Dr. Dr. D’Angelo F. has informed me about the nature and purpose of the operations stated above, possible alternative methods of treatment, the risks involved, and the possible consequences such as but not limited to infection, retarded healing, prolonged discomfort, scars, and other complications which are associated with them. I hereby acknowledge that I understand the information he has given me. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees or assurances have been made to me as to the result of the treatments, examinations, or procedure(s) performed or contemplated.

3. I hereby acknowledge that alternative remedies and procedures have also been explained, such as proper shoes, padding and strapping, injection therapy, the use of foot or shoe appliances, and/or medications where applicable.

4. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physican responsible for this service.

5. I consent to the photographing or televising of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them. I hereby authorize admittance of qualified and authorized observers to the operating room for the purpose of advancing medical education.

6. I agree to follow all postoperative instructions, treatment, and recommendations deemed advisable by Dr. Shapiro and for the purpose of advancing medical education, I consent to the admittance of observers to the operating room.

7. I hereby authorized Dr Dr. D’Angelo F. to submit for pathological examination, if he deems necessary, the removed tissues resulting from the operation or procedure authorized above.

8. I acknowledge that all blank spaces on this document have been either completed or crossed off prior to my signing.

9. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me or agreements made with me concerning predicting the results of the operation.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR OPERATION

_X___________________________________ ____
(Signature of Patient or Guardian) Date (Witness) Date

____
(Signature of Doctor) Date

PREOPERATIVE EDUCATION LETTER

This letter is meant to inform you about the important issues relating to your upcoming surgery. After reading the information below you will have a full and complete understanding about the risks, benefits, and potential complications that may occur after undergoing your surgery. After reading this information your signature at the bottom will serve to inform your physician that you understand and agree with what is contained herein. Please ask for clarification about anything you do not understand or disagree with. You have the right at any time to refuse your surgery.

Alternatives – Alternatives to surgery include doing nothing (living with the pain), physical therapy, orthotics (custom shoe inserts), injections, padding, shoe changes, braces, and/or casts. Some or all of these may have already been attempted prior to surgery. Some of these options may not be appropriate for your condition. In certain cases (for example, traumatic injury) there may be no alternatives to surgery.

Benefits – Benefits may include decreased pain, improved appearance, improved ability to wear shoes, and decreased risk of recurrence.

Risks – Risks of surgery include but may not be limited to pain; infection; numbness; tingling; failure to correct the original condition; scarring; poor skin healing; poor, delayed, or misaligned bone healing (nonunion, malunion); transfer of pain to another area of the foot or leg; recurrence of the original condition; need for further surgery; blood clot in the leg or lung; reaction to anesthesia or medication; circulatory complications; variation in toe alignment; occurrence of lesions in adjacent areas; prolonged swelling; nerve entrapment; rejection of implanted material (ex. screw, pin, wire, plastic joint). Patient recovery from surgery varies as to pain, swelling, and numbness. Complete recovery may vary from weeks to months.

Smoking – Smoking has been shown to decrease the healing potential of bone, leading to slow, delayed, and/or nonunion of bones. Smoking also increases the risk of poor skin healing as well as increasing the risk of medical complications during your surgery.

Compliance with Postoperative Instructions – You are expected to comply fully with all pre- and postoperative instructions. If you feel you will have difficulty following some or all of your instructions let your physician know before surgery. Adjustments to your care may be made in consultation with your physician. You are expected to show up on time for all follow-up appointments. Failure to do so may result in suboptimal healing or one of the above complications.

Pain Management – Your physician will determine the postoperative pain management regimen and will take your requests into consideration, but he will make the final decision regarding the most appropriate prescriptions based on a full review of your medical history and circumstances. Be sure to alert your physicians to any allergic or adverse reactions to any drugs in the past. Narcotic pain medication will be limited to a maximum of 2 months and may be discontinued prior to this time period as determined by your doctor. Any pain after this time period will be handled with non-narcotic methods.

Consent Form – The consent for surgery form will not be changed once it is signed by the patient and physician. Be sure to ask about the addition of any other procedures prior to signature of the consent form. Do not sign the consent paperwork if you have any unanswered questions or disagree with any of the content therein.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR OPERATION AND EDUCATION INFORMATION.

X_________________________________ ____

(Signature of Patient or Guardian) Date (Witness) Date

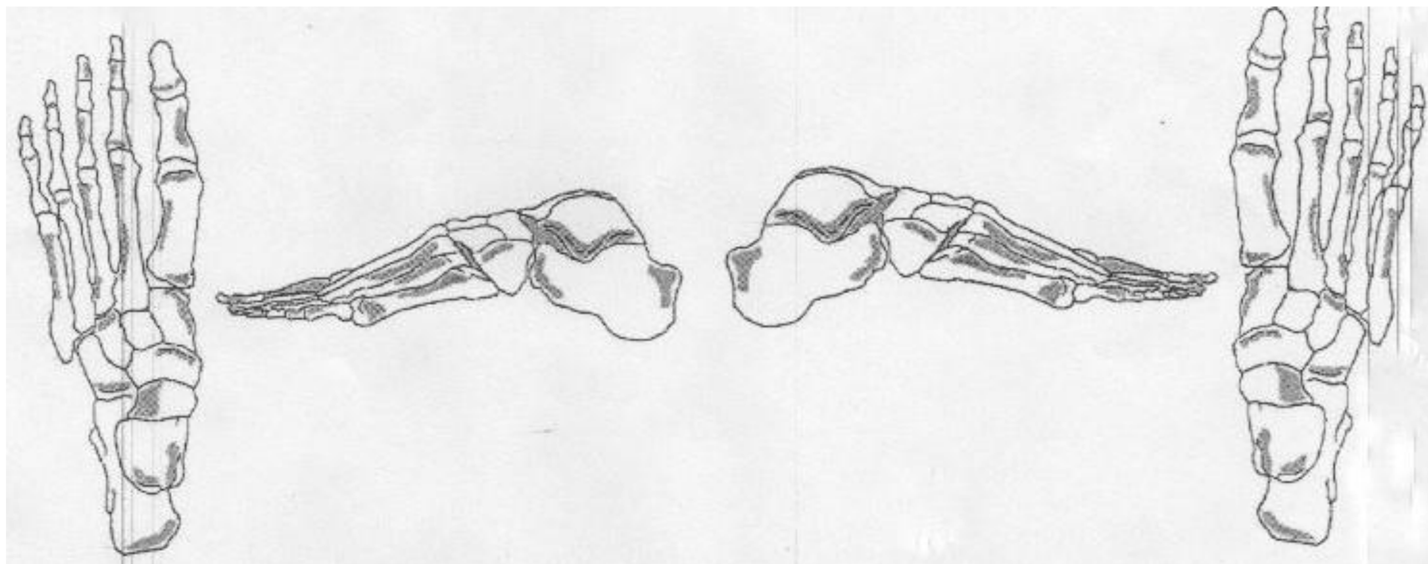
____

(Signature of Doctor) Date

SURGICAL PLANNING DIAGRAM

PATIENT NAME: X ___________________

LEFT FOOT RIGHT FOOT



These diagrams were explained to me and I understand them.

Patient Signature_ X ____ Date_______________

Witness Signature____ Date_______________

Physician Signature____ Date_______________

The following has been explained to me by Dr. D'Angelo F. or his staff:

1. The diagnosis explained in lay terms.
2. Alternative methods of treatment.
3. Description of the surgery utilizing x-rays, models, or pictures with explanation in lay terms.
4. Postoperative care, healing time, and activity restrictions.
5. Possible use of postoperative orthotics.
6. No guarantees for success.
7. Potential risks and complications.
8. Preoperative instructions have been given.
9. All questions have been answered satisfactorily and to my understanding.

Patient Signature_ X ____ Date_______________

Witness Signature____ Date_______________

Physician Signature____ Date_______________