

The Foot and Ankle Wellness Center of Western Pennsylvania

Surgical Consent

Date: _____ Time: _____ a.m. p.m

I am aware that I suffer from physical ailments which have been previously diagnosed as:

I authorize Dr. _____ and any other physician, nurse or technician that he/she may select to assist the doctor in the performance of the following procedure(s):

On _____
(Name of patient)

I understand that the condition will probably not disappear naturally and may become worse if surgery is not performed. I have been told that there are other possible methods of treatment, but they cannot be guaranteed.

I have been told that my surgeon may designate assistants to work with him/her. In the event my surgeon becomes disabled before or during surgery. I am aware that he/she may delegate a substitute.

I am aware that there are risks of complications and injuries involved in surgery and anesthesia, including but not limited to: Pain, overcorrection, undercorrection, numbness, tingling, burning, swelling, scarring and or adhesions, infection, recurrence, needed for further surgery, hospitalization or any of the following:

And these risks were explained to me to my satisfaction.

If, during the course of the procedure(s), any unforeseen conditions arise which necessitate additional procedures, I further request and authorize the above named physician or his/her designated assistant to perform such procedure(s), which; in his/her professional judgment are necessary and desirable, including, but not limited to, procedures involving pathology and radiology. The authority granted here shall extend to remedying conditions that are not known at the time the procedure(s) commenced.

I am aware that the practice of medicine is not an exact science, and that I acknowledge that no guarantees have been made to me as the result of the procedure(s).

I am aware that any disposed tissue may be sent for a pathology report at The Foot and Ankle Wellness Center of Western Pennsylvania's discretion.

I have discussed all of these matters and I HEREBY CONSENT to the surgery and to the anesthesia that has been described to me with the understanding that if the surgery discloses other conditions requiring further surgical intervention. I ALSO CONSENT to such additional surgery. MY SIGNATURE ACKNOWLEDGES THAT I HAVE BEEN ABLE TO UNDERSTAND WHAT I HAVE READ AND WHAT HAS BEEN EXPLAINED TO ME, AND I AGREE TO PROCEED WITH THE SURGICAL PROCEDURE(S) AS OUTLINED HEREIN.

Patient' Signature: _____

Doctor's Signature: _____

Witness Signature: _____

Signature: _____ / _____
Next of Kin or legal Guardian (Relationship)

Ford City Location
313 Ford Street
Ford City, PA 16226
P: (724) 763-4080
F: (724) 763-4083

Butler Location
100 Evans Road
Butler, PA 16001
P: (724) 841-0188
F: (724) 841-0189
Toll Free: (844)-FOOTDOC (366-8375)

Monaca Location
3578 Brodhead Road
Monaca, PA 15061
P: (724) 775-6168
F: (724) 775-2633

Grove City Location
675 N. Broad Street Ext, Suite 2
Grove City, PA 16127
P: (724) 450-1144
F: (724) 450-1140



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