Elmhurst Foot & Ankle Center
183 W 1st St,
Elmhurst, IL 60126
office@footankleil.com

FOOT & ANKLE CENTER
ELMHURST
(630)-530-3338

Schaumburg Foot & Ankle Center
1375 E Schaumburg Road, Ste 210
Schaumburg, IL 60193
www.footankleil.com

Consent for Surgery

Patient: _____ **Date of Birth:**_____

You have the right and responsibility to make decisions about your health care. Your doctor can give you information and advice, BUT IT IS YOUR DECISION WHETHER OR NOT TO HAVE SURGERY OR TREATMENT.

1. I give my permission to Dr. _____ to perform the following operation/procedure/treatment on me:
   _____
   _____ _____
   Site/Location Side
   The purpose of the operation or procedure is to: _____
   _____

2. I understand that the **potential benefits and outcomes** of the operation/procedure/treatment include, but are not limited to:
   _____
   _____
   _____

3. I understand that the **potential risks and complications** of the surgery/procedure/treatment include, but are not limited to [check only those that apply]:

____ Infection	____ Allergic reaction to suture or other implanted materials
____ Redness and/or swelling of operated areas	____ Damage to blood supply/circulation (such as blood clots)
____ Poor healing of incisions and/or bones	____ Damage to nerves (burning, tingling, stinging, numbness)
____ Failure of the incisions and/or bones to heal	____ Loss of implant through degeneration/breakdown
____ Excessive bleeding	____ Loss of toe, foot, limb or life
____ Operation/procedure/treatment may not work	____ Permanent swelling/enlargement of toe, foot or leg
____ Condition or pain may come back	____ Paralysis/paraplegia/quadriplegia
____ Condition/disability may get worse	____ Brain damage
____ Bad or allergic reaction to anesthesia	____ More treatment or surgery may be needed
____ Painful or large scars	____ Significant or permanent pain (such as CRPS)
____ Calluses or sores may develop on the foot	____ Stroke/heart attack/death
____ Fracture/break or dislocation of a bone	____ Other: _____
____ Swollen toe/stiff toe/shorter toe/lifted toe	____ Other: _____
____ Difficulty in walking/wearing shoes/playing sports	____ Other: _____

4. **My doctor has discussed other options** for this surgery/procedure/treatment for my condition with me. These include but are not limited to [check only those that apply]:

____ Wide shoes or change in shoe gear	____ Orthotic shoe inserts	____ No treatment at all
____ Periodic care	____ Change in job	____ Other: _____
____ Antibiotics	____ Injections	____ Other: _____
____ Padding and strapping	____ Physical therapy	____ Other: _____

5. **Serial Procedures** – I understand that I may/will receive a series of the same treatments over a time period. **N/A** _____

6. I understand that other health care providers such as surgical assistants, physician assistants, nurses, and other surgical staff may assist the doctor named above in performing my surgery. A surgical resident(s) may participate in some or all of the surgery. I give my permission for them to do so.

7. I consent to the use of anesthesia, except for _____**N/A** _____.

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8. I consent to the taking of x-rays; blood samples and/or urine samples for laboratory testing; and other tests that may be necessary.
9. I consent to the use and transfusion of blood and blood products if my doctor feels it is necessary. I understand that my doctor will not be responsible for any bad reactions as a result of a transfusion.
10. I consent to the disposal of any tissues or parts which may be taken out during the procedure.
11. I have told my doctor about all my allergies. (LIST ALLERGIES) _____
12. I have told my doctor:
    a. About all of the drugs I take, including prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs;
    b. About all of my medical conditions such as allergies, pregnancy, epilepsy, herpes, HIV/AIDS, diabetes, circulation problems, etc. that I am aware of;
    c. If I smoke;
    d. If I use alcohol .

    I will accept full responsibility for any problems with my treatment that may result because of my failure or refusal to tell my doctor about these things.

13. I understand that no guarantees or promises have been made to me about the results of this operation/procedure/treatment.

14. I understand that sometimes during surgery, it is discovered that additional surgery may be needed. I give my doctor permission to do additional surgery if he/she feels it is necessary.

I certify that I have read, or had the form read and explained to me, and that I fully understand its contents. I have been given ample opportunity to ask questions. My questions have been answered to my satisfaction. All blanks or statements that required completion were completed before I signed this form. I drew a line through all statements that I do not approve before I signed this form.

I understand the risks, benefits, and alternatives to the proposed operation, procedure, or treatment. I consent to the operation, procedure, or treatment to be performed. **YES** _____ **NO** _____

_____ _____
Signature of patient *Date/Time*

_____ _____
Witness *Date/Time*

The patient is unable to consent because: _____
Therefore I consent for the patient.

_____ _____
Legal Representative of the patient *Date/Time*

_____
Relationship

I declare that I have personally explained the above information to the patient or the patient's legal representative.

_____ _____
Physician *Date/Time*

Revised September 2024