

CENTRAL KANSAS PODIATRY ASSOCIATES
STATE OF THE ART PODIATRIC CARE

Benjamin W. Weaver, DPM, CWS, FACFAOM, FAPWCA, FCCWS, FAAPPM

Physician Certified in Wound Care - CMET

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CONSENT FOR NAIL BIOPSY

PATIENT: _____ DATE: _____ CHART # _____

I hereby authorize Dr. Weaver/Bassi to perform upon me the following surgical procedure: Nail biopsy. This is a minimally invasive surgical procedure that may or may not require anesthesia, whereby a part of the nail, nail plate, and subungual material is removed for laboratory analysis. Unlikely, but potential, complications of this procedure include local bleeding, infection, or prolonged pain.

If anesthesia is used, I consent to the administration of anesthesia under the direction of the above named physician as he deems advisable.

The nature and purpose of this biopsy, the risks/benefits of leaving the process undiagnosed, and the possibility of complications have been fully explained to me by the above named doctor. I acknowledge that no guarantee or assurance has been made to me regarding the results that will be obtained from this procedure.

I certify that I have read and fully understand the above consent to biopsy and the associated explanations given by the above listed doctor.

SIGNATURE OF PATIENT: _____ DATE _____

The foregoing consent was read, discussed and signed in my presence and in my opinion; the person(s) so signing did so freely with full knowledge and understanding.

SIGNATURE OF WITNESS: _____ DATE _____