933 N Topeka
Wichita, KS 67214
316-269-3338 office
316-264-5516 fax

1515 S. Clifton Ste. 103
Wichita, KS 67218
316-687-3338 office

613 N. Main St.
El Dorado, KS 67042
316-320-3338 office
316-322-8192 fax

CONSENT FOR CHEMICAL MATRIXECTOMY\ NAIL AVULSION PROCEDURE

Patient _____ Date_____

I hereby authorized Central Kansas Podiatry to treat the condition or conditions that have been diagnosed, and to perform the following operation or procedure:

Permanent removal of the lateral medial bilateral border/s of the

1st 2nd 3rd 4th 5th toe/s right left foot using phenol/ NaOH. Temporary Avulsion

The nature of this operation or procedure has been explained to me by my physician and I have been informed of the risks involved therein, (including but not limited to) the risk of unusual blood loss, infection, heart irregularity, shock and death that are attendant to the performance of any surgical procedure. Other potential complications of the above procedures include but are not limited to: possible pain, numbness, swelling, discoloration, ***possible infection, or possible regrowth***.

I AM ALSO AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THE OPERATION OR PROCEDURE.

I further authorize the performance of such other procedures, in which the said physician may deem advisable at the time of or during surgery, and I authorized the use and disposition of any tissues removed for diagnostic or scientific purposes.

I have been instructed and understand post-operative home care instructions.
_____ (patient/parent/responsible party or guardian's initials)

_____ or _____
Patient Signature Parent/Responsible Party/Guardian

_____
Witness