

### Wart Removal with Electro-Cauterization

DATE: \_\_\_\_\_

Name of Procedure/s: Wart removal with electro-cauterization \_\_\_\_\_ warts \_\_\_\_\_

foot.

Procedure/s in Layman’s Language: Removal of warts with heat \_\_\_\_\_ warts \_\_\_\_\_ foot.

I authorize the performance on above procedure/s under the direction of: Foot and Ankle Care at OMG, Dr. Brandon Rogers, DPM, 535 Main Street, Olean, New York 14760. (716) 376-2282.

Doctor: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I do not have a pacemaker.

I consent to the performance of operation and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above-named doctor or his associates or assistants may consider necessary or advisable in the course of the operation.

I consent to the administration of such anesthetics as may be considered necessary as advised by the physician responsible for this service.

For the purpose of advancing medical education, I consent to the admittance of observers to the operation.

I consent to the disposal of any tissue or parts which may be removed and sent to pathology

The Nature and purpose of the operation, possible alternative methods of treatment, limitations and risks involved, and the possibility of complications has been fully explained to me. No guarantees or assurance have been given by anyone as to the results that may be obtained.

A satisfactory result is expected but the following possible risks, complications, or effects may occur: Infection, Prolonged Swelling, Numbness and Tingling, Stiffness, Delayed Healing, Scar or Inflamed Scar, Recurrence, Delayed Walking or Standing, Anesthetic Complications, or other as follows:

Remarks: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_