FOOT AND ANKLE CARE AT OMG

535 MAIN STREET. OLEAN, NEW YORK 14760 TEL (716) 376-2282, FAX (716) 376-2281

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. Kelly 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:_____