Consent to Toenail Surgery

WASHINGTON INSTITUTE
ORTHOPEDIC CENTER
Diagnosis and Treatment of Orthopedic Injuries

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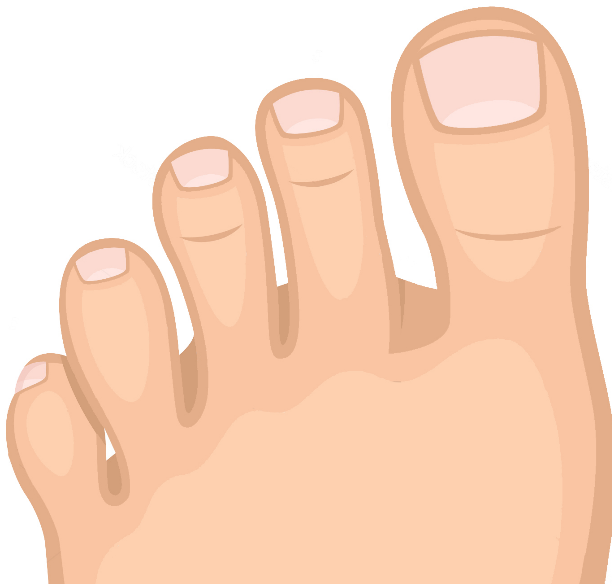
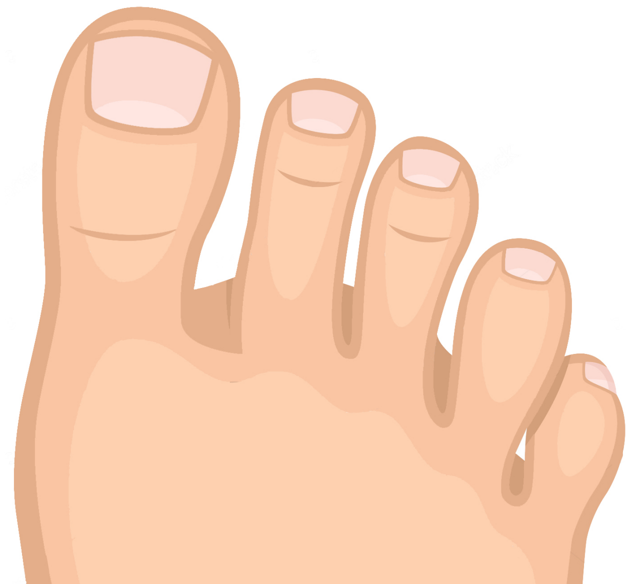
Patient: ____________________

Date ____________________

I authorize and request Dr. L. Kirk Lorimer to perform surgery for permanent removal of all or part of my toenails as described below:





LEFT FOOT
5th toe • 4th toe • 3rd toe • 2nd toe • Big toe

RIGHT FOOT
Big toe • 2nd toe • 3rd toe • 4th toe • 5th toe

For Treatment of: ____________________

Alternative Treatment: Trimming of the nail.

I consent to the use of local anesthesia, and have no previous allergy to local anesthesia. I understand and desire that the portion of the nail which is removed ***will not*** regrow. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

Possible complications may include, but are not limited, to: infection, recurrence, prolonged drainage, misshaped re-growth of the nail, and prolonged pain.

Surgical Fee: $ ____________________

Patient or Guardian Signature: ____________________

Date ____________________

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