FOOT AND ANKLE ASSOCIATES OF WISCONSIN

262- 542-3779 (phone)

AUTHORIZATION FOR SURGERY

PATIENT NAME_____

1. I hereby authorize Drs, Vavra, Sanicola, Galati, Sella, Veldkamp, Philipsen or Xiong and whomever he/she may designate as the assistants to perform the following:

   PARTIAL - TOTAL: NAIL MATRIXECTOMY REMOVAL -TENOTOMY- INCISION & DRAINAGE (circle) TO:

   RIGHT GREAT TOE, 2nd, 3rd, 4th, 5th LEFT GREAT TOE, 2nd, 3rd, 4th, 5th (circle)

2. The nature and purpose of the surgery, possible alternative methods of treatment and potential risks and complications involved have been fully explained to me.

3. I consent to the administration of anesthesia to be applied by or under the directions of Drs. Vavra, Sanicola, Galati, Sella, Veldkamp, Philipsen or Xiong and to use such anesthetics as he/she may deem advisable with the exception of _____.

4. I acknowledge that NO GUARANTEE of assurance has been made as to the results that may be obtained.

5. I consent to the disposal by the doctor or whomever he/she may designate of any tissue that may be removed.

6. I certify that I have read and fully understand the above authorization for surgery, that the explanations therein to were made, and that all blanks were filled in before I signed my name below.

PATIENT SIGNATURE_____ DATE_____

PARENT/GUARDIAN_____DATE_____

RELATIONSHIP TO PATIENT_____DATE_____

WITNESS_____DATE_____