**IADVL- Academy**

**SIG (Special Interest Group) Dermatosurgery**

**2019-2020**

**Consent form for Nail Surgery**

(Please acknowledge the source when using this consent form)

**Mr/Mrs./ Miss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age: Date:**

**Case Record No:**

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis:**

**Name of the PROCEDURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nail being operated**:

**I have been informed that**

* The purpose of this procedure is to relieve my painful nail and to prevent/ reduce its recurrence in the future.
* In this procedure, my painful broad nail will be partially avulsed and a chemical will be applied at the base (lateral nail matrix) so that the future nail will come out less broad and will not impinge on to the lateral nail fold and cause its swelling and pain.
* The procedure is done under local anesthesia where my doctor will first administer a local anesthetic solution at the base of my digit (on both the sides) so that the digit being operated will become anesthetized.
* After getting the procedure done, I will need to wear open-toed shoes to accommodate the bulky dressing over the operated area. I will also be required to take oral medication prescribed by my doctor, other than getting the dressing changed regularly.
* I have been asked to avoid prolonged standing/ walking or cycling for a period of at least 2 days post-procedure. This will reduce post-operative swelling in the treated digit.
* I have also been asked to try to keep the operated limb in an elevated position for the first two days, as far as possible.
* Clinical results may vary between individuals. Most patients do not require further surgical treatments in the affected nail with gradual regrowth of nail over few months. On occasion, there are patients that do not respond to treatments and so the outcome cannot be guaranteed.

**I was also informed about**

* The other alternative methods of dealing with ingrown nail including conservative wait and watch; as well as their benefits and disadvantages.
* I understand that for ideal results, this procedure can be combined with radiofrequency, surgical options, etc.
* No guarantee, warranty, or assurance has been made to me as to the results that may beobtained.
* I am also aware that follow-up treatments may be necessary for desired results.

**I also understand that**

* Short-term side effects may include pain and swelling of digit, or temporary numbness. These conditions usually resolve within 2-4 days after treatment.
* In the event of throbbing pain, pulsating pain, or if my digit starts becoming discolored, I need to loosen my dressing completely and report back to my doctor immediately.
* In case I develop pain later during the course of my dressings, or I develop a pus discharge then I will need to report to my doctor for the need for better antibiotics.
* My digit is likely to completely heal by 1-2 weeks, the stage at which I can stop wearing any dressing. I have also been told that in occasional patients, mild watery discharge may continue for more than two weeks, and they may need to wear a dressing for more than 2 weeks.
* Following is my current status regarding smoking
	+ \_\_\_\_\_\_\_ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.
	+ \_\_\_\_\_\_\_ I am a smoker or use tobacco/ nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

**Additionally**

* I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however my name or identity will not be disclosed and complete confidentiality will be maintained.
* By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the possible risks of Ingrown Nail Surgery.
* I have informed the doctor about any/all drug allergies that I have.
* Before each treatment, I will inform the doctor if I have taken any new medications since my last treatment.
* I also agree to comply with the recommended aftercare instructions.

**Consent**

I authorize Dr ----------------------- and her /his designated staff to perform procedure. Further, my signature below indicates my consent for the treatment described and my agreement to comply with the requirements placed on me by this consent form.

My questions regarding the same have been adequately answered.

I hereby release Dr ------------------ and her/his designated staff from any liability associated with above procedure. The payment and fee structure have been informed to me and I agree to abide by the same.

**SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE (in case of minor)**

**Name:**

**SIGNATURE OF WITNESS SIGNATURE OF OPERATING DOCTOR**

**Name: Name:**

**Date: Time: Place:**

**Was Translation to the Patient’s language required: Yes/ No**

**SIGNATURE OF THE TRANSLATOR**

**(Name and Relationship with the patient, if any)**