



**DR. SCOTT O'CONNOR**

Fellow, American College of Foot & Ankle Surgery  
Diplomate, American Board of Podiatric Surgeons  
Certified in Foot, Reconstructive Rearfoot/Ankle Surgery

Normal – (309) 807-0384

Pontiac – (815) 842-6551

Eureka – (309) 467-2371

**ACKNOWLEDGEMENT OF INFORMED CONSENT TO OPERATION OR PROCEDURE**

1. I hereby request and authorize Dr. O'Connor and such assistants he/she might select to treat the condition(s) which appear indicated. The proposed procedure to treat my condition is

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_. Initial \_\_\_\_\_

2. My doctor has explained to me the diagnosis of my condition and the nature and purpose of the procedure for which this consent is given, as well as the risks and complications associated with this procedure to include, but not limited to, **numbness, delayed healing, continued pain, prolonged swelling, recurrence of deformity, infection of tissue or bone, scar tissue, worsening or no improvement of deformity, loss of length or range of motion, nerve entrapment, RSD (painful nerve disorder), further surgery, reaction to materials, or blood clot.** In addition, he/she has advised me of the feasible alternative forms of treatment including modification of activity or shoe gear, padding, anti-inflammatories, injection, or nothing.

Initial \_\_\_\_\_

3. I am aware that during the course of the authorized procedure, expected conditions may be revealed that require an extension of the authorized procedure or performance of a procedure different than stated in paragraph #1. I, therefore, authorize the above named physician and selected assistant(s) to perform such surgical and/or medical procedures as necessary in his/her professional judgment. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure(s).

Initial \_\_\_\_\_

4. Where anesthesia services may be required as part of this operation or procedure, I have been advised and acknowledge that I am aware that there are risks and complications involved in the administration of anesthesia. The complications may include nausea, vomiting, chest problems, or more serious risks associated with anesthesia. When airways are used, there may be soreness of the throat with increased sputum and coughing; and there may be damage to decayed or loose teeth, porcelain caps or bridgework. I consent to the administration of anesthesia.

Initial \_\_\_\_\_

5. Any organs, tissues, or members of my body removed during the course of the procedure may be examined or disposed of in accordance with accustomed practice and regulations.

Initial \_\_\_\_\_

6. Circle one: (I do), (I do not), consent to the presence of observers, approved by the attending surgeon/physician, during the course of the procedure for the purpose of advancing health education.

Initial \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Authorized Person

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

