YOU ARE A HIGH RISK PATIENT
You have Poor Circulation

This may be due to various reasons, such as diabetes, tobacco use or hardening of the arteries. Essentially, your feet are receiving less blood because your arteries are defective. Unfortunately, this is a progressive condition. Nicotine from tobacco use constricts your blood vessels which results in diminished circulation to your feet. The amount of constriction is directly related to the amount of nicotine in your body, so we strongly urge you to discontinue tobacco use due to the decreased healing potential. Diminished circulation from tobacco use is preventable

If this disease affects only your large arteries, surgery may replace these arteries. If small arteries are affected, there is no effective cure.

If a significant artery to a part of your foot fails, you may develop an infection or wound that will not heal even with the best of medical care. Even antibiotics are ineffective in the presence of poor circulation. The drug cannot reach the tissues in a concentration that will kill the germs. This is why some people require amputations.

The greatest risk to you is to leave your condition untreated. Professional care can decrease your risk, but this risk cannot be eliminated. Pain may develop whether or not your condition is treated or not treated.

In summary:

Even with proper care you can develop serious complications
We will try to minimize your exposure to complications
Let's work together

CONSENT FOR TREATMENT
Peripheral Vascular Disease/Diabetic/Smoker

I, _____, understand that I have poor circulation and this is a progressive condition. I further understand that the risk of disease or complications inherent in my condition is not totally eliminated with professional care and treatment. I also understand that I am at greater risk from this condition.
I understand that I have a systemic condition for which I have been advised to seek treatment from a physician. If I smoke, I understand that I have been advised to enroll in a cessation program for smokers. I UNDERSTAND AND ACKNOWLEDGE MY PODIATRIST WILL TREAT ONLY MY FOOT CONDITIONS(S) AND WILL NOT TREAT MY SYSTEMIC CONDITIONS.

DR. ALESSI HAS EXPLAINED THE ABOVE INFORMATION AND THE ALTERNATIVES / RISKS TO ME. I UNDERSTAND THIS EXPLANATION AND I AUTHORIZE MY PODIATRIST TO TREAT MY FOOT CONDITION(S).

_____
Patient's Signature Date

_____
Witness Date

IF SURGERY IS TO BE PERFORMED, THIS FORM IS TO BE USED IN CONJUNCTION WITH A SURGERY CONSENT FORM.