

Plastic Surgery
Hand and Wrist Surgery
Diplomate American board of Plastic Surgery
Certificate of Added Qualification, Surgery of the Hand
Gary D. Salomon, MD.
1199 Bush Street Suit 640
San Francisco CA 94109
Email: drgarysalomon@yahoo.com

INFORMED SURGICAL CONSENT

NAME OF PATIENT: _____

DATE OF SURGERY: _____

I hereby request and authorize Gary D. Salomon, M.D. and whoever he may designate as his assistant to perform upon the above named patient, the following operative procedure(s)

AND TO PERFORM during, preceding and following the operation any other operation(s) and procedure(s) in addition to or different from that which is contemplated, whether or not arising from presently unforeseen conditions which Gary D. Salomon, M.D. or his associates, or assistants may consider necessary or advisable in the course of the operation in the interest of the patient.

The nature and purpose of the operation with other alternative methods of conservative treatment, the risks involved, and the possibility of complications have been fully explained to me. No guarantee or assurance has been given to me as to the surgical results that are anticipated. I understand that tissue and/or bone will be removed during surgery. I have initialed the diagram on the reversed of this form which indicated those portions to be removed. I further consent to the disposal of any tissue or portions of bone which may be removed during the course of surgery.

I hereby authorize and request Gary D. Salomon, M.D. to administer such local anesthetics and other medications that he deems advisable and necessary in the performance of this surgery. I am not allergic or sensitive to any drugs, medications, or material other than

It has been explained to me that a satisfactory result is expected, but that the following complications or effects could or may occur: swelling; stiffness; numbness; infection; injury; suture reaction; flail toe; rotation; delayed healing; scar; medication and recurrence.

I hereby certify that I have read and fully understood that above consent to the operation, that the explanations therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any were stricken in my presence and before I signed.

DATE: _____
(Signature of patient and/or Guardian)

DATE: _____
(Witness)