INGROWN TOENAIL SURGERY Consent Form

Patient Name:

I consent to surgical treatment of my ingrown toenail(s), which may include:

- Partial or total nail avulsion (removal of part or all of the toenail)
- Phenolisation of the nail matrix (chemical destruction to prevent regrowth)
- Wedge resection of the nail and nail bed

The procedure will be performed under local anaesthetic. The affected area will be numbed, and the problematic portion of the nail will be removed. Chemical cauterisation may be used to prevent regrowth of the nail edge.

Purpose and Expected Benefits

- Relief of pain and discomfort
- Resolution of infection
- Prevention of recurrence
- Improved nail appearance and function

Material Risks and Complications

I understand that all surgical procedures carry risks. Common and serious risks include:

Common risks (may affect up to 1 in 10 people):

- Temporary pain, swelling, or bruising at the surgical site
- Bleeding requiring pressure or additional treatment
- Temporary restriction of activities for 1-2 weeks
- Altered sensation or numbness in the toe
- Nail regrowth (5-10% recurrence rate with phenolisation)

Less common but serious risks:

- Infection requiring antibiotics or further surgery
- Delayed wound healing
- Permanent nail deformity or dystrophy
- Allergic reaction to local anaesthetic or phenol
- Chronic pain or discomfort
- Damage to surrounding tissues
- Unsatisfactory cosmetic result

Alternatives

I understand alternative options include:

- Conservative management (proper footwear, nail trimming, antibiotics if infected)
- Referral to podiatrist or orthopaedic surgeon
- No treatment (with ongoing symptoms)

Post-Operative Care and Recovery

I understand that:

- I must keep the dressing dry for 48 hours
- I should elevate my foot and rest for 24-48 hours
- I may experience discomfort for several days
- I should avoid strenuous activity for 1-2 weeks
- Full healing may take 2-6 weeks
- I must attend follow-up appointments as scheduled
- I should contact the clinic if I develop signs of infection (increased pain, redness, swelling, discharge, fever)

Patient Declaration

I acknowledge that:

- The procedure, risks, benefits, and alternatives have been explained to me in terms I understand
- I have had the opportunity to ask questions and all my questions have been answered satisfactorily
- No guarantees have been made about the outcome
- I consent to photography for medical records purposes
- I understand I may withdraw consent at any time before the procedure
- I am not aware of any reason why I should not undergo this procedure

Patient Signature: _____ **Date:** _____

Patient Name (print):_____