

**Consent for Treatment –
Patient with Peripheral Vascular Disease or Diabetes**

I, _____, understand that I have poor circulation and that this is a progressive condition. I know that risk of disease or complications are inherent to my condition, with or without professional care and treatment.

I understand that I have the following treatment options:

- No treatment
- Special/wider shoes
- Shoe padding
- Foot soaks
- Periodic foot care (nail/callus trim)
- Antibiotics and/or other medications
- Limiting my walking/weight bearing time
- Change in occupation
- Surgery
- Other (please specify)

I understand that with any treatment of my condition, including surgery, the following risks are present:

- Infection
- Delayed healing
- Wound deterioration or breakdown
- Additional danger of artery/vein clotting (thrombosis)
- Skin necrosis/skin ulcer
- Loss of toe, foot, limb, or life
- Drug reaction
- Other (please specify)

I understand that my poor circulation increases my risk of developing these complications, and may make my subsequent care and treatment more difficult and outcomes more uncertain.

I also understand that not treating my foot problems presents serious risks to my health. My foot problems could get worse and lead to new complications, including the loss of a limb or my life.

I have been informed that I have peripheral vascular disease / diabetes and have been advised to see a vascular surgeon or other medical doctor. I understand and acknowledge that my podiatrist will treat only my foot and ankle conditions and will not provide direct treatment for my peripheral vascular disease / diabetes.

My podiatrist has explained the above information to me. I understand the explanation, and authorize my podiatrist to treat my foot condition(s).

Patient signature: _____

Date: _____

Witness: _____

Date: _____

DPM signature: _____

Date: _____

Questionnaire for Patients with Diabetes

Patient Name: _____ Date: _____

- How long have you had diabetes? _____ Months _____ Years
- How many times a day/week/month (circle one) do you check your blood sugar?

- Who checks your blood sugar? (circle one) You / Your doctor / Someone else
- What is your blood sugar normally? _____ mg/dl
- What was your most recent blood sugar reading? _____ mg/dl When was it taken?

- Are you taking medication for diabetes? Yes / No (circle one) If yes, name of medication _____ Dose _____
 - If you are on insulin, how long have you been taking insulin? _____ Weeks
_____ Months _____ Years
 - Name of insulin used _____ Dosage _____
- Do you have a history of foot sores that do not heal? Yes No (circle one) If yes, which foot? Left / Right
- Do you have any loss of sensation in your feet or toes, including burning, tingling, and/or numbness? Yes / No
- Do you have cramping in your legs or feet? Yes / No
 - If yes, when? (circle all that apply) Walking / At Rest / At Night / Sitting
- Have you been hospitalized or had surgery in the last five years for a condition related to your diabetes? Yes / No
 - If yes, please explain:

- Do you have a primary care physician? Yes / No
If yes, please complete the following:
 - Physician's Name: _____
 - Address _____

 - Date you were last seen _____ Month _____ Year
- Do you see a diabetic specialist? Yes / No
If yes, please complete the following:
 - Diabetic specialists name: _____
 - Address _____

 - Date you were last seen _____ Month _____ Year
- Other than this office, have you ever seen a foot specialist? Yes / No
If yes, please complete the following:
 - Foot specialist's name: _____
 - Address _____

 - Date you were last seen _____ Month _____ Year
- Have you ever owned diabetic shoes prescribed by a physician? Yes / No
 - If yes, who prescribed them? _____
 - Date prescribed: _____ Month _____ Year _____