Documentation Tools:
Good Documentation Doesn’t Have to be Time-Consuming

Barbara Bellione, RN, CPHRM, ARM
10/7/15

Fact
Failure to adequately document is problematic in most claims.
– Informed consent
– History and physical
– Patient non-adherence
– Other consent issues
– Referrals and consultations
– After-hours phone calls
INFORMED CONSENT

Case Study

Case

• 41-yr. old F
• C/o discomfort in toes and heels
• Wanted to discuss surgical correction
• Exam
  – Flexible contractures of toes 2-5 bilat.
  – Protuberance on posterior aspect of both heels
  – X-rays showed spurring of heels and contractures of the toes, bilat.
• Diagnosis - retrocalcaneal spur and hammertoe syndrome toes 2-5, bilat.
Case (cont.)

- **Plan**
  - Reappointed in 1 month for pre-op visit
  - Wear wider shoes and use orthotic inserts
- **4 months later**
  - Pt. returned
  - Conservative measures did not relieve pain
  - Wanted to proceed with surgery
- **Surgery 3 weeks later**
  - Arthroplasty of 2-5 PIPJ, bilat.
  - Arthroplasty of 2nd DIPJ, bilat.
  - Hemiphalanectomy of middle phalanx of 5\textsuperscript{th} digit, bilat.
  - Excision/resection of posterior heel spurs, bilat.

Case (cont.)

- **1 wk. post-op**
  - “healing as expected”
- **2 wks. post-op**
  - Pt. had been on trip that required long distance driving → increased swelling in feet
  - Podiatrist postponed suture removal for one week due to swelling
- **3 wks. post-op**
  - Sutures removed
Case (cont.)

- 7 wks. post-op
  - Pt. c/o tenderness in toes & pain in feet when walking
  - Noted mild edema of toes and heels
  - No drainage, infection, exudate or color change
  - Recommended cont. proper shoe gear & Epsom salt soaks daily

- Subsequent visits
  - Pt. c/o pain & burning sensation in heels, L > R
  - Pod. recommended revision of L heel surgery
  - Pt. initially agreed, but cancelled surgery and failed to return

Allegations

- Failure to offer and/or recommend conservative treatment prior to and as an alternative to surgery
- Improper diagnosis of hammertoes
- Unnecessary surgery for hammertoe correction when hammertoes did not exist
- Failure to obtain informed consent
Defending the Claim

• Medical records supported diagnosis of hammertoes
• Conservative treatment was offered
• Greatest exposure – lack of documentation of informed consent

Podiatrist’s Pre-op Progress Note

A 41 y.o. Blk female was seen this date at the office for the full evaluation of pain in the feet and the heels. The patient states she would like to have her toes and her heels surgically corrected at this time. The patient states that most of the pain is there at times. Patient states at times, she has a difficult time in walking. Patient states that none of the conservative treatment renders any resolution.

Vas: DP/ PT = 2/4 B/L, TG = WNL, CFT= 3 see B/L.
   (-) Pallor, (-) Rubor

Derm: (+) Thick, mild discoloration on the dorsum on the front of the toes. One notes mild inflammation on the toes, with dome area of redness of the feet at this time. One notes (+) thick tissue at the posterior aspect of the heels B/L.

Neuro:  (+) Sharp/Dull, (+) Light touch, (+) 5.07 MW

Msk:  Mild – High arch of the feet with digital contracture of the toes of the feet at this time. One notes mild inflammation of the toes on some contracture, with exostosis of the heels B/L.

(A) Hammer toes 2nd, 3rd, 4th, 5th B/L.
Retrocalcaneal Spurs

1. CBC/Diff, Chem-7, PT/PTT
2. Risks vs. Benefits
3. Surgical consent
4. Pain Medication
5. Discuss 08/10/2004 as surgery date
PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND ACKNOWLEDGMENT OF RECEIPT OF MEDICAL INFORMATION

IMPORTANT INFORMATION ABOUT THIS DOCUMENT – READ CAREFULLY BEFORE SIGNING:

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. Law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risk of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, and (4) reasonable therapeutic alternatives and risks associated with such alternatives.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything that you do not understand, and we will be pleased to explain it.

1. PATIENT NAME: ____________________________

2. TREATMENT/PROCEDURE:
   Description, nature of the treatment/procedure: Surgical removal of painful bone tumor from the right hand palm by incision, incision, palm amputation.
   Purpose: To remove painful bone tumor.
   Patient Condition: Patient’s diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in item 2 of this consent form is indicated and recommended:
4. MATERIAL RISK OF TREATMENT/PROCEDURE:
   i) All medical or surgical treatment involves risks. Listed below are those risks determined by your doctor
   associated with this procedure that we believe a reasonable person in your (the patient’s) position would likely
   consider significant when deciding whether to have or forgo the proposed therapy. Please ask your physician
   if you would like additional information regarding the nature or consequences of these risks, their likelihood of
   occurrence, or other associated risks that you might consider significant but may not be listed below.

   ( ) Additional risks (if any) particular to the patient because of a complicating medical condition are:

   (c) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain
   damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from waist down), the
   loss or loss of function of any organ or limb, infection, bleeding, and pain.
   Risks generally associated with transfusion of blood or blood components if necessary in connection with
   major surgical procedures include fever, transfusion reaction which may include kidney failure or anemia, heart
   failure, hepatitis, AIDS (acquired immune deficiency syndrome), and other infections.

5. REASONABLE THERAPEUTIC ALTERNATIVES AND THE RISKS ASSOCIATED WITH SUCH ALTERNATIVES ARE:

ACKNOWLEDGEMENT, AUTHORIZATION AND CONSENT

6. (a) NO GUARANTEES: All information given me and, in particular, all estimates made as to the likelihood of
   occurrence of risks of this or alternate procedures or as to the prospects of success, are made in the best
   professional judgement of my physician. The possibility and nature of complications cannot always be
   accurately anticipated and, therefore, there is and can be no guarantee, either express or implied, as to the
   success or other results of the medical treatment or surgical procedure.
   (b) ADDITIONAL INFORMATION: Nothing has been said to me, no information has been given to me, and I have not
   relied upon any information that is inconsistent with the information set forth in this document.
   (c) PARTICULAR CONCERNS: I have had an opportunity to disclose to and discuss with the physician providing
   such information, those risks or other potential consequences of the medical treatment or surgical procedure
   that are of particular concern to me.
   (d) QUESTIONS: I have had an opportunity to ask, and I have asked, any questions I have about the proposed
   treatment or procedure, and all such questions were answered in a satisfactory manner.
   (e) AUTHORIZED PHYSICIAN: The physician (or physician group) who is authorized to and will administer or
   perform the medical treatment, surgical procedure or other therapy described in item 2 is:
   [Name of authorized physician or group]

   (f) PHYSICIAN CERTIFICATION: I HEREBY CERTIFY that I have provided and explained the information set forth
   herein, including any attachment, and answered all questions of the patient or the patient’s representative,
   concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.
   [Signature of Physician] [Date and Time]
• Podiatrist
  – He held a thorough informed consent discussion with the patient, including informing her of alternative treatment options and the potential risks of the procedures he performed

• Patient
  – The podiatrist did not advise her of the specific type of surgery he was going to perform or of the risks and benefits of and alternatives to surgery
Outcome

• Decided to take to trial
  – Jury verdict would be a credibility determination between pt. and podiatrist
  – Podiatrist articulate, straightforward and credible
  – Patient not so credible

  Defense verdict!

While We Did Get a Defense Verdict...

• Filing of lawsuit to trial - 7 years
  – Stress of lawsuit
• Defense cost - $80,000
• Lost time from office
  – Deposition
  – 2 days at trial
A Podiatric-Specific Informed Consent Form

The informed consent form should be reviewed with the patient and signed by the patient PRIOR to the date of surgery, at a surgical consult or pre-surgery visit.

It should not be reviewed for the first time and signed on the day of surgery.
Consent for Surgery

Patient: _________________________________

Date of Birth: ____________________________

You have the right and responsibility to make decisions about your health care. Your doctor can give you information and advice, but IT IS YOUR DECISION WHETHER OR NOT TO HAVE SURGERY OR TREATMENT.

1. I give my permission to Dr. ____________________________ to perform the following operation/procedure/treatment on me: ____________________________

2. I understand that the potential benefits and limitations of the operation/procedure/treatment include, but are not limited to:

   - Potentially benefit from surgery, but there are risks involved.
   - There is a risk of infection, allergic reaction, or other complications.
   - Surgery may cause scarring, pain, or discomfort.
   - Surgery may have long-term effects on the patient's health.

3. I acknowledge that the potential risks and complications of the surgery/procedure/treatment include, but are not limited to:

   - Infection
   - Allergic reaction to materials used in surgery
   - Damage to adjacent organs and structures
   - Blood clots
   - Nerve damage
   - Kidney failure
   - Heart attack or stroke
   - Death

4. I understand that by signing this consent form, I am also agreeing to:

   - Follow all post-operative instructions
   - Attend check-up appointments
   - Follow all post-operative pain management instructions
   - Attend physical therapy appointments

5. Social Procedures – I understand that I will receive a list of the social procedures over a time period not to exceed ______ days. Please sign below.

6. I understand that other health care providers such as surgeons, anesthesiologists, nurses, and other surgical staff may assist the doctor in performing my surgery. A surgical resident may participate in some or all of the surgery.

7. I consent to the use of anesthesia, except for ______.

8. I consent to the taking of x-rays, blood samples and/or urine samples for laboratory testing, and other tests that may be necessary.

9. I consent to the use and transfusion of blood and blood products if my doctor feels it is necessary. I understand that my doctor will not be responsible for any blood reactions as a result of a transfusion.

10. I consent to the disposal of any tissues or parts which may be taken out during the procedure.

11. I have told my doctor about my allergies, ________

12. I have told my doctor:
   a. About all of the things I take, including prescription and over-the-counter medications, herbal products, and nutritional supplements.
   b. About all of my medical conditions such as allergies, pregnancy, epilepsy, heart disease, diabetes, chronic conditions, etc., that I am aware of.
   c. If I smoke.
   d. If I use alcohol.

13. I will accept full responsibility for any problems with my treatment that may result because of my failure or refusal to tell my doctor about these things.

14. I understand that sometimes during surgery, it is discovered that additional surgery may be necessary. I give my doctor permission to do additional surgery if further treatment is necessary.

15. I certify that I have read, or had the form read and explained to me, and that I fully understand its contents. I have been given ample opportunity to ask questions. My questions have been answered to my satisfaction. All issues or concerns that required clarification were completed before I signed this form. I have read and understood all statements that I did not approve before I signed this form.

I understand the risks, benefits, and alternatives to the proposed operation, procedure, or treatment. I consent to the operation, procedure, or treatment to be performed.

______________________________
Signature of Patient

Date/Time

______________________________
Witness

Date/Time

The patient is unable to consent because.

______________________________
Legal Representation of Patient

Date/Time

______________________________
Witness

Date/Time

I declare that I have personally explained the above information to the patient or the patient's legal representative.

______________________________
Physician

Date/Time
Case Study

PATIENT H&P
Case

• 37-yr-old F, very athletic
• C/o painful bumps on feet bilat. of few years duration R>L
• Diagnosis
  – Hallux abducto valgus, bilat.
  – Tailor’s bunion, bilat.
  – Dislocation of the 2nd MPJ, right
  – Hammertoes of digits 2-5, right
• Treatment options discussed
  – Pt. opted for surgery as she had tried conservative measures in past without success

Case (cont.)

• Surgery R foot 3 months later
  – Bunionectomy with distal osteotomy
  – Second metatarsal osteotomy
  – Arthroplasty of toes 2-5
  – Excision of cyst
  – Tailor’s bunionectomy
• Slow recovery – c/o pain in 2nd, 3rd and 4th interspaces
Case (cont.)

• 6 months post-op
  – Back to surgery for neuroma excisions of the 2nd & 3rd interspaces with tenotomy and capsulotomy of 5th MPJ

• No improvement in pain
• 5 months later - another surgery
  – Excision of recurrent 4th interspace neuroma
  – Capsulotomy
  – Scar revision
  – Pin removal
• No relief from pain in forefoot

Case (cont.)

• Saw orthopedic surgeon
  – c/o pain, 5th toe in varus and 2nd & 3rd toes were “crooked up”
  – Diagnosed recurrent neuroma at R 3rd interspace
  – Subsequently performed surgery to remove neuromas at 2nd & 3rd interspaces and scar tissue
• Continued to c/o pain
Case (cont.)

- To another orthopedic surgeon
  - Diagnosed CRPS
  - Reviewed pre- and post-op X rays taken by podiatrist
  - Told pt. she did not need surgeries performed by podiatrist
- Pt. no longer able to work or participate in sporting activities

Allegations

- Initial surgery performed by the podiatrist was unnecessary and unjustified
- Initial surgery was improperly performed
- Failure to provide sufficient information for informed consent
- Failure to timely diagnose CRPS and refer for treatment
Defending the Claim

- Bunions difficult to discern on pre-op X-rays
- Initial pre-op H&P documentation limited – did not support need for surgery
- Records failed to describe any problem or deformity at the digital level, other than the 5th toe, prior to surgery
- No description of the patient’s complaint history or location of her complaints
- No documentation of podiatrist’s rationale for surgery
PROGRESS NOTES

10/28/2015 19

P. M.方向 UP -> OK

- Some questions answered
- All normal
- Discharge plan
- No issues
- Discharge instructions
- Final days / communication
- Will be ready

Dr. Pic

PRE-OPERATIVE CONSULT

3/5/09. Dr. Pic \textit{discussed} with Dr. Pic about the need to perform the operation.

- Patient history
- Risks, alternatives
- Consent to surgery attached
- Surgical plan explained
- Risk explained
- \textit{Review} completed
- \textit{Explainations}
- \textit{Explainations}
- \textit{Explainations}

SIGNED ___________________________ DATE _____________
Defending the Claim (cont.)

• Positive aspects
  – Informed consent was thoroughly documented
  – Can have CRPS in absence of malpractice

Outcome

Resolved prior to trial for large sum due to lack of documented justification for the initial surgery
PATIENT HISTORY

Common Allegations

• “I can no longer participate in the activities I used to do”
• “I didn’t have any pain prior to surgery, now I am in pain”
• “I could not stay off my feet, I had too many responsibilities”
• “I didn’t need the surgery”
**Lower Extremity Examination**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Measurement</th>
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<tr>
<td>Pulse</td>
<td>R L</td>
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<td>Skin</td>
<td>R L</td>
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<tr>
<td>Doppler</td>
<td>R L</td>
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<tr>
<td>Other</td>
<td>R L</td>
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<td>CFT</td>
<td>sec sec</td>
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<tr>
<td>Vascular</td>
<td>R L</td>
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<td>Emphysema</td>
<td>R L</td>
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<tr>
<td>Telangiectasia</td>
<td>R L</td>
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<td>Varicose</td>
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<tr>
<td>Pitting</td>
<td>R L</td>
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**Neurologic:**

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<th>Sensation</th>
<th>R L</th>
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<tr>
<td>Position</td>
<td>R L</td>
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<tr>
<td>Vibration</td>
<td>R L</td>
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<td>Muscle</td>
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<tr>
<td>Strength</td>
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**Deformity:**

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<th>General</th>
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<td>Nails</td>
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<td>Hyperkeratosis</td>
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<td>Varicose</td>
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<td>Other</td>
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**PATIENT NON-ADHERENCE**

<table>
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<tr>
<th>Structural/Biomechanical</th>
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<tr>
<td>Foot Type</td>
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<tr>
<td>Arch</td>
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<td>ST/Forefoot</td>
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<tr>
<td>Heel Pain</td>
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<tr>
<td>Tib/Calf/Tarsal</td>
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<tr>
<td>Metatarsal/Plantar</td>
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<td>Forefoot/Lesser Metatarsal</td>
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<td>Hallux/1st Metatarsal</td>
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<td>Digits/Long MPJ</td>
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<tr>
<th>Diagnostic Testing</th>
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<td>Test</td>
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<th>Diagnosis/Impression</th>
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<th>Plan of Treatment</th>
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<th>Patient Discussion</th>
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REFUSAL OF CARE FORM

Patient: ___________________________ Age: __________

Medical condition at issue: ____________________________________________

Person being advised (if other than patient): _____________________________

Physician advising: ____________________________

The physician named above has advised that I, or an individual for whom I am a legal representative, undergo the following test(s), referral(s), consultation(s), treatment(s), or procedure(s):

____________________________________________________________________

Doctor [name of doctor] has explained the above test(s), referral(s), consultation(s), treatment(s), or procedure(s) to me. In doing so, he/she has explained to me the risks and benefits of his or her recommendation; the alternatives, if any, to this recommendation; and the risks and consequences of not receiving the recommended test(s), treatment(s), or procedure(s). Specifically, Doctor [name of doctor] has advised me of the following material risks as refusing the above recommended medical care:

____________________________________________________________________

I have had the opportunity to ask questions about the proposed recommendation and the risks associated with my refusal of care, and Doctor [name of doctor] has answered my questions I have asked to my satisfaction.

Despite the recommendation of Doctor [name of doctor] and with the knowledge I have regarding this recommendation, I have decided NOT to undergo/pursue the test(s), referral(s), consultation(s), treatment(s), or procedure(s) listed above. I understand that my refusal of this recommended medical care may seriously affect my health or the health of the person under my guardianship.

[Patient/Legal Representative] ___________________________ Date: ___________ Time: ___________

I have recommended the above medical care for this patient. To the best of my knowledge, the patient or patient’s legal representative understands the material risks associated with refusal of the above care, including the specific risks listed above.

[Physician] ___________________________ Date: ___________ Time: ___________

Dear [Patient]:

Despite our attempts to schedule your [post-operative/follow-up] appointments at a time convenient for you, you have missed [number] appointments. We have communicated to you [method of communication – by mail, in person, by phone, at the last visit, etc.] the importance of receiving [post-operative/follow-up] care for [patient’s condition].

I would like to repeat the possible risks that could occur to you by not keeping your [post-operative/follow-up] appointments:

____________________________________________________________________

Please call our office immediately to schedule an appointment as soon as possible.

Sincerely,

(Doctor)
Dear 

This letter will serve as formal notice that I will no longer be able to provide pediatric care to you because [REASON]. Some language for reasons includes:

- I am retiring, moving out of the area, etc.
- You have consistently failed to follow my advice and recommendations.
- You have not followed through with arrangements to pay the balance due on your account.
- There are important differences in our views of medical care and treatment.
- Of the present nature of our physician-patient relationship.
- Of your continued inappropriate behavior in my office.

I will continue to provide care to you until [DATE – at least 30 days from the date of this letter]. This period of time should give you ample opportunity to select a podiatrist of your choice from the many competent practitioners available in the area. Upon receipt of your written request, I will forward a copy of your medical record to your new podiatrist. A medical records release authorization form is enclosed for your convenience.

[If the patient has a condition that requires continued medical treatment or follow-up, include the following: It is important for you to continue with treatment because of your current medical condition. Therefore, I encourage you to select a physician promptly and place yourself under his/her prompt and ongoing care.]

Very truly yours,

____________________ DPM

OTHER CONSENT ISSUES
Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of minor patient: __________________________ Date of Birth: __________________________

I certify that I am the parent and/or legal guardian of ________________________________________

☐ I authorize __________________________ to bring my child to office visits with __________________________

(name of person bringing child to office) (name of physician)

☐ I authorize the minor child named above to come alone to office visits with __________________________

(name of physician)

and I consent to the examination and/or treatment of my child.

This authorization:
☐ is effective on __________________________.
☐ is effective from __________________________ to __________________________.
☐ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home phone number: ______________ Office phone number: ______________
Cell phone number: ______________ Other phone number: ______________

I reserve the right to revoke this authorization at any time by writing to the above-named physician.

Parent/Guardian Signature: __________________________ Date: __________________________

Sample notice of office policy to routinely document patient care utilizing photography. This notice may be included in the practice’s standard consent form and HIPAA Notice of Information Practices form.

"I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that [name of practice] will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in [name of practice]'s policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative."

Note: This consent does not authorize the use of the images for other purposes, such as teaching or publicity. A separate consent for photography form should be used for such purposes.
Consent for Photography, Videotaping, or Other Imaging for Media or Educational Purposes

Patient's Name: _____________________________  Patient's Date of Birth: _____________________________

I give my consent to have photographs, videotaped images, or other images made of myself or patient's name, I understand and agree that these images may be used by [name of practice] for the purpose outlined below.

____ Teaching purposes, which includes being shown to other patients.
____ Advertisements by [name of practice]
____ Placement on [name of practice]'s website
____ Other

______________________________
Signature of patient/legal representative

______________________________
If legal representative, relationship to patient

______________________________
Date

Sample Off-Label Drug/Device Use Consent Form
(to be used in conjunction with “Informed Consent Form”)

I have been informed by Dr. _____________________________ that the drug/device _____________________________ will be used during my procedure/treatment, _____________________________ for the purpose of _____________________________ I understand that this drug/device has not been approved by the Food and Drug Administration (FDA) for this purpose.

Dr. _____________________________ has discussed with me:
1) the benefits of using this drug/device for my procedure/treatment which include: _____________________________

2) the alternatives of using this drug/device for my procedure/treatment which include: _____________________________

3) the potential risks and complications of using this drug/device for my procedure/treatment which include: _____________________________

______________________________
I have been given ample opportunity to ask questions and my questions have been answered to my satisfaction. I understand the risks, benefits and alternatives to the use of _____________________________ as outlined in this form and:

☐ I give my consent _____________________________

☐ I do not give my consent _____________________________

______________________________
signature of patient/legal representative

g date/time

I declare that I have personally explained the above information to the patient or the patient's legal representative.

______________________________
date/time

______________________________
date/time

______________________________
date/time
Sample E-mail Consent Form
[office letterhead]

I am: ____________________________

a) an established patient of [name of doctor or office practice],
b) the legal representative of an established patient,

I may want to communicate with [name of doctor or office practice] and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that [name of doctor or office practice] cannot guarantee the security and confidentiality of e-mail communication. [name of doctor or office practice] will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with [doctor or office practice name] by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

4) Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
5) We will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.
6) I authorize the e-mailing of my health information to you or to a third party designated by you.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL—CALL 911. Also, do not use e-mail for urgent problems. If you have an urgent problem, call our office (office phone number) or go to an urgent care facility.

GUIDELINES FOR E-MAIL COMMUNICATION
1) Include the general topic of the message in the "subject" line of your e-mail. For example, "advice," "prescription," "appointment" or "billing question."
2) The e-mail message should not be time-sensitive. While we may try to respond to e-mail messages daily, it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be referred to us by regular telephone or in person.
3) Include your name and phone number in the body of the message.
4) Review your message to make sure it is clear and that all relevant information is included before sending.
5) Send us an e-mail confirming receipt of our message after you have received and read an e-mail message from us.
6) If your e-mail requires a response from us, you have not heard from us within three (3) working days, call our office to follow up to determine if we received your e-mail.
7) Take precautions to protect the confidentiality of e-mail such as

safeguarding your computer password and using screen savers.

CONSENT
I: ____________________________

a) ____________________________
b) ____________________________

I understand that either I or [name of doctor or office practice] may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by so advising [name of doctor or office practice] in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from [name of doctor or office practice].

_________________________
(print name)

_________________________
(signature)

_________________________
(date)
Case Study

REFERRALS AND CONSULTATIONS

Case

• 60-yr-old male
• To podiatrist for 2\textsuperscript{nd} opinion re: ankle fusion
• 6’2”/ 265 lbs.
• Family history
  – Older brother died from blood clot
  – Younger brother died from MI
• Medical history
  – Hypertension
  – Elevated cholesterol
Case (cont.)

• C/o severe pain around anterior talofibular ligament & calcaneal fibular ligament
• R ankle pain, swelling, instability
• X-rays & MRI performed
• Diagnosis
  – Exostosis R talus
  – Ankle instability consistent with ligament strains & ruptures R ankle
• Treatment options discussed – conservative vs. surgery
  – Pt. elected surgery

PCP Visit 4 Days Later

• Regularly scheduled appt. for check-up and to review blood work that had been drawn a few days earlier
3 Days Later

- Back to podiatrist for pre-op consultation - informed consent obtained
- Surgery Center called PCP’s office asking them to fax the patient’s H&P and recent blood work
- PCP instructed his staff to send the latest progress note and results of the latest blood work

Surgery Performed The Following Week

- Right ankle arthroscopy
  - Excision of os trigonum
  - Excision of calcaneal spur
  - Excision of talar spur, dorsal and lateral
  - Excision of fibular spur
  - Hypertrophic synovectomy
  - A Brostrom of ATFL
  - Drilling of osteochondral defect
- Pt. placed in below knee cast and instructed to return in 1 wk. for initial post-op appt.
Case (cont.)

• Post-op Day 1
  – Podiatric assistant called patient to check on him – doing “great”

• Post-op Day 2
  – Patient’s wife called podiatry office – spoke with staff member
    • Patient “feeling weird” - foot did not hurt, but his body “felt funny”
    • Wife thought husband’s symptoms could be related to anesthesia wearing off, but could also be related to a blood clot since her husband’s brother died of a blood clot after knee surgery
    • Staff member told wife that the podiatrist was not in the office, but another doctor was present and could see the patient or she could take her husband to the ED

  (patient chose not to go to the office or the ED)

Case (cont.)

• Post-op Day 8
  – Patient passed out in his home
  – EMS found pt. to be in cardiac arrest → CPR
  – To ED via ambulance
    • Noted to have R lower leg edema
    • Resuscitation efforts unsuccessful
    • Wife stated pt. had complained of pain & swelling of the right leg that morning
  – Autopsy → death resulted from PE that originated as a DVT in the right lower extremity
Lawsuit Filed Against Podiatrist & Corporation

• Allegations
  – Failure to order preoperative testing for coagulation disorders given family history of blood clots
  – Failure to place patient on anticoagulants postoperatively
  – Failure to provide adequate follow-up care postoperatively
  – Failure of office staff to instruct patient to go to the hospital emergency department immediately when wife called to report unusual symptoms

Problems with Defense

• Defense podiatric expert did not think pre-op testing for coagulation disorders or post-op anticoagulants was required by SOC, but if pressed, would have to admit he would have prescribed post-op anticoagulants in this case

• Defendant podiatrist testified in deposition:
  – Pt. had risk factors for development of DVT/PE
  – He did not communicate his concerns to the pt.’s PCP either verbally or in writing
  – Pt. did not receive formal medical clearance for surgery
Problems with Defense (cont.)

- PCP testified in deposition:
  - He was aware pt. would soon have foot/ankle surgery, but did not think he had come to see him for preoperative medical clearance
  - No one from the podiatrist’s office contacted him or his office staff about the patient’s upcoming surgery
  - If it had been a pre-surgical visit, he would have ordered additional tests and would not have cleared him for surgery until those tests were completed

- Office staff member who spoke to the patient’s wife did not insist that the pt. come to the office or go to the ED, nor did she relay importance of seeking immediate care

Outcome

Resolved during mediation for over a million dollars
Medical Referral Form

Doctor: ___________________________ Date: ______________________

Thank you for agreeing to evaluate our patient. I am sending you the following information to assist you with your evaluation. Please contact me should you need additional information.

Patient Name: ___________________________ DOB: __________

Address: ___________________________ Phone# 1: __________

_________________________ Phone# 2: __________

Primary Complaint/Reason for Referral: ___________________________

________________________________________

Other Medical Problems: ___________________________

________________________________________

Current Medications: ___________________________

________________________________________

Allergies: ___________________________

I look forward to receiving your report.

Referring Physician’s Name: ___________________________

Address: ___________________________

Phone: ___________________________ Fax: ___________________________

E-mail: ___________________________


[OFFICE NAME]

REFERAL LOG

Week of: ___________________________

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<tr>
<th>Patient’s Name/DOB</th>
<th>Referred To</th>
<th>Reason for Referred</th>
<th>Date Referred</th>
<th>Referral Appl. Date</th>
<th>Date Report Received in Office</th>
<th>Date Report Reviewed by Doctor</th>
<th>Date Report Reviewed with Pt.</th>
<th>Follow-up Needed (Yes/No)</th>
<th>If applicable, followed up by* (Name)</th>
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*Details recorded in patient’s chart.
### Case Study

**AFTER HOURS PHONE CALLS**
Case

• 42-yr-old F
• c/o painful corns L 4th toe & R 5th toe
• 2 wks. later, in-office surgery
  – Arthroplasty of R 5th toe
  – Osteotripsy of L 4th and 5th toes
• Initial post-op visit
  – Cellulitis L 4th toe
    • Removed sutures to facilitate drainage and obtained C&S
  – Remainder surgical sites healing appropriate w/o signs of infection
  – Prescribed Omnicef - to return in 1 wk.

Case (cont.)

• Saturday prior to scheduled appt. on Monday
  – Pt. called answering service due to c/o severe pain, fever & constant throbbing in L foot
  – Partner was on call & returned pt.’s call
  – Partner reportedly told pt. she was doing too much and to rest, keep foot elevated and keep her appt. on Monday
Case (cont.)

• Sunday prior to scheduled appt. on Monday
  – Pt. called answering service and spoke to partner again
  – Pt. concerned because redness & warmth spreading up foot & 4th toe was more swollen & deeper red color
  – Partner reportedly told pt. she should give antibiotics time to work & keep appt. on Monday

Case (cont.)

• Instead, pt. went to ED that Sunday
• Admitted
  – Seen by Infectious Disease
  – DX cellulitis of L fourth and 5th toes
  – IV antbx.
• Followed by podiatrist after discharge
• Subsequently diagnosed with osteomyelitis
Allegation Against Partner

- Failure to aggressively evaluate the patient’s emerging infection which led to osteomyelitis

(The podiatrist was also sued, but case against him was dropped)

Defending the Claim

- The partner did not document any of his phone conversations with the patient
- He could not recall whether or not he received any phone calls from the patient
- The patient could produce proof through her phone records and answering service records that calls were made
Outcome

Resolved prior to trial for several thousand dollars