THE HAND & WRIST CENTER
Specialists in diagnoses, rehabilitation and surgery

NEEDLE APONEUROTOMY PROCEDURE CONSENT FORM

PATIENT'S NAME (PRINTED): _____

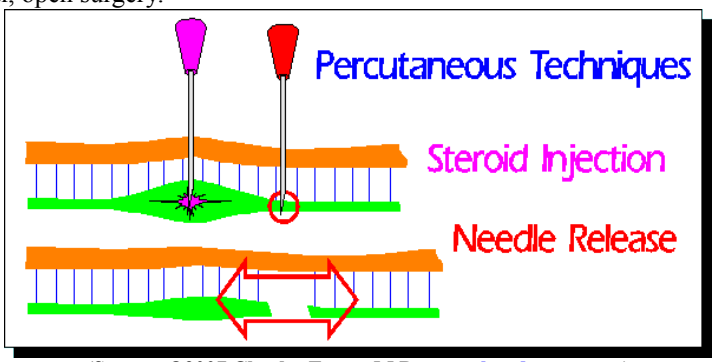
PROCEDURE DATE: _____

PHYSICIAN / SURGEON: **ROSS NATHAN, M.D.**

PROCEDURE NAME: **NEEDLE APONEUROTOMY**

SURGICAL SIDE: RIGHT LEFT **DOMINANT HAND:** RIGHT LEFT

Needle Aponeurotomy (N.A.) is a minimally invasive procedure by which tight palmar cords (contractures) are released through the process of percutaneously penetrating the soft-tissue layer (fascia) located directly under the palmar skin surface. Simultaneous Cortisone injections are administered during this process, which help discourage reformation of the cells that cause these palmar cords. Once the cord has been penetrated (cut) by the needle, the "break" allows for the contracture to potentially release, thus allowing digital and palmar extension to occur immediately. The primary focus of this procedure is to provide as many releases as possible while minimizing the possibility to reform scar tissue, which causes these cords. N.A. is not a cure for Dupuytren's Disease (Contractures), but it is a less-invasive method by which this condition can be addressed without the need for traditional, open surgery.



(Source: ©2007 Charles Eaton, M.D., www.handcenter.org)

RISKS ASSOCIATED WITH THIS PROCEDURE (include, but are not limited to):

- Open wound resulting from in-office contracture release.
- Bleeding at contracture release site.
- Infection of open wound.
- Nerve irritation and/or injury.
- Tendon irritation and/or injury.
- Superficial discomfort during and after the procedure.
- Scarring at contracture release site.
- Local hypopigmentation of skin at injection site (following local anesthesia injection).
- Recurrence of contracture.
- No relief from procedure attempt.

I have been informed of the above-stated and above-illustrated procedure, and I fully accept all potential benefits and risks associated with this procedure. In addition, I hereby give my consent to have my procedure photographed and/or video-recorded for the purposes of documenting my procedure and for Research and Development purposes. I have been informed that my name and/or identity will never be released in association with these photographs or video-recording, unless I have provided permission.

PATIENT SIGNATURE: _____ **DATE:** _____

OFFICE WITNESS NAME: _____ **DATE:** _____

OFFICE WITNESS SIGNATURE: _____