Western Pennsylvania Oral and Maxillofacial Surgery PC

CONSENT FOR SURGERY - Biopsy

Patient Name_____
Date

If you have any questions, please ask your doctor BEFORE signing.

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

1. My condition has been explained to me as: Lesion of the
2. The procedure(s) necessary to treat the condition(s) has/have been explained to me and I understand the treatment to be: Biopsy of the lesion located
3. I realize that there may be other forms of treatment applicable to my situation as well as the choice of no treatment at all.
4. My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and in this specific instance they include, but are not limited to:

A. Post-operative discomfort and swelling that may require several days of at home recovery

B. Prolonged or heavy bleeding that may require additional treatment.

C. Injury or damage to adjacent teeth or fillings.

D. Post-operative infection that may require additional treatment.

E. Stretching of the corners of the mouth that may cause cracking or bruising, and may heal slowly.

F. Restricted mouth opening during healing; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exists.

I. Injury to the nerve resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue (including taste) and which may persist for several weeks, month or in rare instances, permanently.

L. Allergic reactions (previously unknown) to any medications used in treatment.

5. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.
6. ANESTHESIA

The anesthesia I have chosen for my surgery is:

☐Local Anesthesia

☐Local Anesthesia with Intravenous Sedation and or General Anesthesia

FOR PATIENTS RECEIVING IV ANESTHESIA

1. ANESTHETIC RISKS include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be Inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage or even death.

2. YOUR OBLIGATION IF IV ANESTHESIA IS USED

A. Because anesthetic medications cause prolonged drowsiness, you must be accompanied by a responsible adult to drive you home And stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.

B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR SURGERY.**

D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a small sip of water.

INFORMATION FOR FEMALE PATIENTS

1. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the periods of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

CONSENT

I certify that I speak, read, and write English and have read and fully understand this consent for surgery, have had my question(s) answered and that all blanks were filled in prior to my initials

or signature It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed.

Patient (or legal Guardian) Signature

Date