MONESMITH & WOOD
ORAL & MAXILLOFACIAL SURGERY, P.C.

2005 · ST. CHARLES STREET · SUITE 2
JASPER, INDIANA 47546
812/482-2280 · FAX 812/482-4218

611 DUBOIS STREET
VINCENNES, INDIANA 47591
812/882-8888 · FAX 812/882-8398

CONSENT FOR REMOVAL OF CYST OR TUMOR

Patient Name: _____ **Date:** _____

You have the right to be informed about your diagnosis and planned surgery so you may make a decision whether to undergo a procedure or not after knowing the risks and benefits.

1) **Removal of a cyst or tumor (growth) from the jaw, whether easy or difficult, is still surgical procedure. All surgeries have some risks and those may include any of the following:**

   a) Swelling, bruising, and pain. Stretching of the corners of the mouth that may lead to cracking or bruising. Infection that might require more treatment. Loss of nerve or blood supply to teeth which might result in root canal treatment or loss of teeth. Dental implants and/or dental prostheses (bridges, etc.) to replace teeth lost in treatment might be needed at a later date.

   b) Extensive or severe bleeding

   c) Injury of nerves which might result in numbness or change in feeling in the lips, chin, cheek, nose, tongue, teeth, or gums which could be permanent. In the case of tumors, resection (removal) of part or all of a nerve may be necessary, and this would result in permanent loss of feeling or pain. Nerve grafting may be performed at the time of surgery, or at a different surgery, to repair an injured nerve.

   d) In the case of certain tumors, incisions in the skin of the face or neck may be necessary and may result in a noticeable scar; and could also result in injury to nerves which control muscle movement of the face

   e) Bone grafting to replace bone removed with the surgery may be performed at the time of surgery, or at a later date.

   f) In cases involving the lower jaw, the jaw might break at the time of surgery, or days or weeks after surgery. Repair of the fracture may involve bone grafting, wiring or use of metal plates and screws

   g) The tumor cyst might come back and need additional surgery. Follow-up visits and additional x-rays will be necessary to evaluate healing and to look for any return of the cyst or tumor.

2. **I have elected to proceed with the anesthesia(s) indicated below.**

   LOCAL NITROUS OXIDE IV SEDATION GENERAL ANESTHESIA

I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

a) LOCAL ANESTHESIA: Certain possible risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage, and unexpected allergic reactions.

b) INTRAVENOUS SEDATION OR GENERAL ANESTHESIA: Certain possible risks exist that, although uncommon, could include nausea, pain, swelling, inflammation, and/or bruising at the injection site (phlebitis).

c) Rare complications, include allergic or unexpected drug reactions, or other life-threatening conditions.

d) **IF I AM TO HAVE INTRAVENOUS SEDATION OR GENERAL ANESTHESIA, I UNDERSTAND THAT I AM TO HAVE NO FOOD OR DRINK FOR EIGHT (8) HOURS BEFORE MY APPOINTMENT. TO DO OTHERWISE MAY BE LIFE THREATENING.**

e) I have been made aware that certain medications, drugs, anesthetics, and prescriptions which I may be given can cause drowsiness, lack of coordination and awareness. The use of alcohol can increase the effects of these drugs. I have been advised not to operate any vehicle or hazardous machinery and not to return to work while taking such medications, or until fully recovered from the effects of the same. I understand that this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am to be given sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult accompany me until I am fully recovered from the effects of the sedation. **I ALSO UNDERSTAND THAT IF I AM GIVEN AN IV SEDATION, THERE IS NOT GUARANTEE THAT I WILL BE COMPLETELY ASLEEP DURING MY PROCEDURE. I UNDERSATND THAT IN SOME INSTANCES, PATIENTS UNDERGOING SURGERY UNDER IV SEDATION CAN REMEMBER PORTIONS OR POSSIBLY ALL OF THE PROCEDURE, INCLUDING SOME PAIN.**

3. ALTERNATIVE TREATMENT OPTIONS:

_____

I hereby authorize Drs. Monesmith & Wood and their staff to perform the following procedures:

_____

_____

It has been explained to me that during the course of surgery, unforeseen conditions may be revealed which necessitates extension of the original procedure or a different procedure from that which was planned. In rare cases, it may not be possible to continue with the procedure. I authorize my doctor and his staff to perform such procedure(s) that are necessary and desirable in the exercise of professional judgment.

I have had an opportunity to discuss my past medical history with my doctors, including psychological disorders, drug use, medications I am taking, or other problems which may affect t my anesthesia or surgery. I have truthfully revealed all aspects of my health history. It has been explained to me that if I am taking birth control pills that additional, alternative methods of birth control will be necessary while taking any drugs prescribed by this office for my entire cycle.

I understand that although good results are expected, the nature of all possible complications and individual patient differences cannot be accurately anticipated and therefore a perfect result is not and cannot be guaranteed or warranted.

I certify that I speak, read, and write English and have read and fully understand both pages of this consent for surgery and that all blanks were filled in prior to my signing this form. I have discussed the preceding with my doctor and all my questions have been answered to my satisfaction and I have made a voluntary choice to proceed with the proposed surgery.