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ORAL & MAXILLOFACIAL SURGERY, P.C.

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SURGERY CONSENT FOR BIOPSY PROCEDURE

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 after knowing the risks. This disclosure is not meant to frighten or alarm you. The chances of these complications occurring are small. It is simply an effort to make you better informed about your surgery.

POSSIBLE COMPLICATIONS OF:

1. **BIOPSY PROCEDURES**
   a. Post-operative discomfort and swelling which may require several days of at-home recuperation.
   b. Prolonged or heavy bleeding which may require additional treatment.
   c. Post-operative infection which may require additional treatment.
   d. Stretching of the corners of the mouth which may cause cracking and bruising and which may heal slowly.
   e. Restricted mouth opening for several days. This may be related to swelling and muscle soreness and/or stress on the jaw joints (TMJ).
   f. Reactions to medications, anesthetics, suture, etc.
   g. Injury to sensory nerve branches in the area of the biopsy which may result in pain or tingling or numb feeling in the lip, chin, tongue, cheek, gums, or teeth, or in areas of the skin of the face. Usually this disappears slowly over several weeks or months, but occasionally the effects may be permanent.
   h. If bone tissue is removed, healing may take longer, some complications may be more likely (for example, bleeding), and the biopsy report may take longer due to special processing requirements.
   i. Opening the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment.
   j. There is always a possibility of the lesion recurring in the same area, even when it appears to be totally removed. Additional surgery may be required.
   k. Scarring in the area of surgery.
   l. Other_____

2. **ANESTHESIA**
   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 SIX 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 NO GUARANTEE THAT I WILL BE COMPLETELY ASLEEP DURING MY PROCEDURE. I UNDERSTAND 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

a. No treatment

b. _____

c. _____

d. _____

I hereby authorize Drs. Monesmith & Wood and their staff to perform the following procedure(s): _____

I consent to the administration of the following anesthesia:

LOCAL NITROUS OXIDE IV SEDATION GENERAL ANESTHESIA

It has been explained to me that during the course of surgery, unforeseen conditions may be revealed which necessitate 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 doctor, including psychological disorders, drug use, medications I am taking, or other problems which may affect 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.