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

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

CONSENT FOR ORTHOGNATHIC SURGERY

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

You are having orthognathic surgery, and it is important that you understand the benefits and risks of such surgery. This is not minor surgery and you have the right to be fully informed about your condition and the recommended treatment plan. The disclosures in this consent are not meant to alarm you, but rather to provide information you need in order to give or withhold your consent to the planned surgery.

PATIENT NAME_____ **DATE**_____

_____1. I hereby authorize Drs. Monesmith & Wood and any agents, assistants or employees selected by the doctor to treat the condition described as:

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_____2. The surgical procedure(s) planned to treat the above condition(s) has been explained to me, and I under stand the nature of the treatment to be: _____

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_____3. I have been informed of possible alternatives to treatment (if any) including no treatment and/or nonsurgi cal orthodontic treatment.

_____4. My doctor has explained to me that there are certain potential risks and side effects of my surgery, some of which may be serious. They include, but are not limited to:

A. Facial and jaw swelling after surgery, usually lasting several days.
B. Bleeding, both during and after surgery, which may sometimes be severe enough to require blood transfusion.
C. Allergic reaction to any of the medications given during or after surgery.
D. Delayed healing of the bony segments; rarely requiring a second surgery and/or bone graft to repair.
E. Relapse: the tendency for the repositioned bone segments to return to their original position, which may require additional treatment including surgery and/or bone grafting.
F. Bruising and discoloration of the skin around the jaws, neck, eyes, and nose.
G. Diminished sense of smell (if upper jaw surgery is done).
H. A change in cosmetic appearance. Although this is primarily a procedure to restore jaw function, I am aware of some expected change in my appearance. I understand that some other cosmetic changes may result that cannot be exactly predicted, and that no promises have been made as to what extent my appearance will be changed or modified.
I. Loss of feeling, pain, or a tingling numbness in my chin, lips, tongue, gums, or teeth which occurs in a significant number of patients. These symptoms may last for several days, weeks, or months. I have been told that there is some chance that it may be permanent.
J. Possible decreased function of the muscles of facial expression.
K. Scarring from external skin incisions if certain rigid fixation methods are used.
L. Possible need for additional procedures to remove fixation devices, pins, screws, plates, or splints.
M. In certain cases where bone cuts may be made in the narrow space between teeth, there is the possibility of devitalization of those teeth which may require later root canal procedures, and could result in the loss of those teeth. There is also a possibility of devitalization of bone and soft tissue in the area of surgery which may result in some loss of tissue.

N. In upper jaw surgery the sinus will be affected for several weeks, and there may be a need for further sinus surgery to remedy any lingering problems.

O. Postoperative infection which may cause loss of adjacent bone and/or teeth and which may require additional treatment for a prolonged period of time.

P. Change in position of the jaw joints (TMJ) which may cause postoperative discomfort, bite change, and chewing difficulties. If TMJ symptoms exist before surgery, there may be no improvement and even some worsening of these symptoms after surgery.

Q. Stretching of the corners of the mouth with resulting discomfort and slow healing.

R. Inflammation of veins (phlebitis) that are used for IV fluids and medications; sometimes resulting in pain, swelling, discoloration, and restriction of arm or hand movement for some time after surgery.

5. General anesthesia will be used for this surgery and I have been told the risks, including bronchitis, pneumonia, hoarseness or voice changes, cardiac irregularities or other life threatening conditions. I am aware of the importance of not having anything by mouth (including clear liquids unless specifically authorized by my doctor or anesthesiologist) after midnight on the day before surgery. I UNDERSTAND THAT IT IS VITAL THAT I HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO MY ANESTHETIC. TO DO OTHERWISE MAY BE LIFE THREATENING.

6. I realize the importance of providing true and accurate information about my past medical history, including psychological disorders, possible pregnancy, allergies, medications, and history of drug or alcohol use. It has been explained 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. If I misinform my doctor, I understand the consequences may be life threatening or otherwise adversely affect the results of my surgery.

7. I understand that my diet will consist initially of liquids, followed by a pureed, non-chew diet for six to eight weeks following surgery. If my teeth are wired together after this surgery, I understand there are certain associated risks and complications: oral hygiene will be diminished, there may be resulting gum disease, my teeth will feel sightly loose for some time after the wiring, and there is always some concern about airway obstruction. I agree to carry wire cutters or scissors with me at all times when my jaws are wired or banded and to avoid the use of alcohol and activities that may cause airway problems. I understand that good oral hygiene is imperative during this period.

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

_____9. By signing this consent form, I acknowledge that I have read it completely and understand the procedure(s) to be performed, the risks, and the alternatives to surgery. I certify that I speak, read, and write English and have read and fully understood 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 of my questions have been answered to my satisfaction, and I have made a voluntary choice to proceed with the proposed surgery.