INFORMED CONSENT FOR REMOVAL OF CYST OR TUMOR

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

Your preoperative diagnosis is: ________________________________

A final diagnosis will be based on the histopathology report.

Your planned procedure is: ________________________________

Alternative treatment methods include: ________________________________

All surgeries have some risks. They include the following and others:

_____ 1. Swelling, bruising, and pain.

_____ 2. Stretching of the corners of the mouth that may lead to cracking or bruising.

_____ 3. Infection that might require more treatment.
4. Loss of nerve or blood supply to teeth which might result in root canal treatment or loss of the teeth.

5. Extensive or severe bleeding that may need surgical treatment.

6. 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.

7. 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.

8. Nerve grafting may be performed at the time of surgery, or at a different surgery, to repair an injured nerve.

9. 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.

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

11. Dental implants and/or dental prostheses (bridges, etc.) to replace teeth lost in treatment might be needed at a later date.

12. 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.

13. The tumor or cyst might come back and need additional surgery.

14. Follow-up visits and additional x-rays will be necessary to evaluate healing and to look for any return of the cyst or tumor. I agree to return for visits as required by Dr. _________________, or other Oral and Maxillofacial Surgeons involved in my care.
INFORMATION FOR FEMALE PATIENTS

15. I have told my doctor that I use birth control pills. My doctor has told me that some antibiotics and other medications may reduce the preventive effect of birth control pills, and I could conceive and become pregnant. I agree to discuss with my personal doctor using other forms of birth control during my treatment, and to continue those methods until my personal doctor says that I can stop them and use only oral birth control pills.

ANESTHESIA

I have had the opportunity to speak with Dr. ____________ about my options for anesthesia. These options include Local Anesthesia, Nitrous Oxide/Oxygen Analgesia with Local Anesthesia, Oral Medication with Local Anesthesia, Intravenous Sedation, or Deep Sedation/General Anesthesia. After this discussion, I have chosen to have ________________ as my anesthesia. I understand the risks and potential complications of anesthesia to include:

16. Discomfort, swelling or bruising where the drugs are placed into a vein.

17. Vein irritation, called phlebitis, where the drugs are placed into a vein. Sometimes this may grow to a level of discomfort or disability where it may be difficult to move my arm or hand. Sometimes medication or other treatment may be needed.

18. Nerves travel next to the blood vessels where the drugs are placed into a vein. If the needle hits a nerve or if drugs or fluid leaks out of the vessel around a nerve, I may have numbness or pain in the nerve where it runs along the arm. Usually the numbness or pain goes away, but in some cases, it may be permanent.

19. Allergic reactions (previously unknown) to any of the medications used.

20. Nausea and vomiting, although not common, are possible unfortunate side effects. Bed rest, and sometimes medications, may be needed for relief.
___ 21. Conscious sedation and deep sedation/general anesthesia are serious medical procedures and, whether given in a hospital or office, carry the risk of brain damage, stroke, heart attack or death.

___ 22. In situations where a breathing tube is used, I may have a sore throat, hoarseness or voice change.

MY OBLIGATIONS:

___ 23. Because anesthetic or sedative medications (including oral premedication) cause drowsiness that lasts for some time, I MUST be accompanied by a responsible adult to drive me to and from surgery, and stay with me for several hours until I am recovered sufficiently to care for myself. Sometimes the effects of the drugs do not wear off for 24 hours.

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

___ 25. I must have a completely empty stomach. It is vital that I have NOTHING TO EAT OR DRINK for six (6) hours prior to my treatment. TO DO OTHERWISE MAY BE LIFE-THREATENING.

___ 26. Unless instructed otherwise, it is important that I take any regular medications (high blood pressure, antibiotics, etc.) or any medicines given to me by my surgeon using only small sips of water.
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CONSENT

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to surgery and anesthesia. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient’s (or Legal Guardian’s) Signature  Date

Doctor’s Signature  Date

Witness’ Signature  Date