MIDWEST ORAL & MAXILLOFACIAL SURGERY, PA

GREGORY W. HUELER, DDS
NOAH A. SANDLER, DMD, MD

CONSENT FOR BIOPSY PROCEDURE

Patient's Name _____ Date _____

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

You have the right to be given pertinent information about your proposed surgery so that you may make an informed decision as to whether or not to proceed. A biopsy is a surgical procedure whereby a sample of tissue is taken for microscopic study to determine if it is normal.

In your case, the area of concern is:_____

1. I understand that a biopsy requires an incision(s) in my mouth or on the skin which will require stitches, and sometimes the removal of bone tissue. It has been explained that there are certain risks associated with the surgery, including (but not limited to):

   A. Post-operative discomfort and swelling that may require several days of at-home recuperation.
   B. Prolonged or heavy bleeding that may require additional treatment.
   C. Post-operative infection that may require additional treatment.
   D. Stretching of the corners of the mouth that may cause cracking and bruising and which may heal slowly.
   E. Restricted mouth opening for several days. Sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
   F. Reactions to medications, anesthetics, sutures, etc.
   G. Injury to sensory nerve branches in the area of the biopsy which may result in pain or a 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 into 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.

2. **ANESTHESIA**

   The anesthetic I have chosen for my surgery is:

   ☐ Local Anesthesia ("Novocaine")
   ☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia ("Laughing Gas")
   ☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia and Oral Sedation
   ☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia and IV Sedation

3. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, 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 rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

4. **YOUR OBLIGATIONS 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 ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
   D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using a small sip of water.**

5. I understand that I may be given appointments for long-term follow-up care after my biopsy, even if the biopsy report is benign. I recognize the importance of returning for such follow-up that, if not done, may allow progression of my condition to a state requiring additional care or further surgery, or the lesion may recur and become a threat to my health. I agree to comply by regularly scheduling exams as instructed and to notify this office if I suspect a change in my condition.

CONSENT

I understand that no guarantee can be promised and I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature _____ Date _____

Doctor's Signature _____ Date _____

Witness' Signature _____ Date _____