CONSENT FOR ORTHOGNATHIC SURGERY AND ANESTHESIA

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

Patient Name: __________________________

I hereby authorize Dr. ____________________ and staff to perform the following procedure: 

______________________________________________________________________

______________________________________________________________________

and to administer general anesthesia.

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

Orthognathic surgery is being planned for you, and it is important that you understand the benefits and risks of such surgery.

_____ 1. 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 which may require a blood transfusion, both during and after surgery.
  ____ 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, eyes and nose.
  ____ G. Diminished sense of smell (if upper jaw surgery is done).
  ____ H. A change in cosmetic appearance. I am aware of some changes in my appearance that cannot be exactly predicted.
  ____ I. Injury to nerve branches in the upper & lower jaw resulting in numbness, pain, or tingling of the chin, lips, cheek, gums, or tongue. This numbness or pain may in rare instances be permanent.
  ____ J. Possible decreased function of 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. Injury or loss to teeth next to bone cuts.
  ____ N. Sinus injury in the upper jaw
  ____ O. Post-operative infection.
  ____ P. Injury to jaw joints (TMJ) which may cause post-operative discomfort, bite change and chewing difficulties. If TMJ symptoms existed before surgery, there may be no improvement and even some worsening of
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.
S. Tooth and gum problems (periodontal disease) resulting in loss of teeth.

2. General anesthesia will be used for this surgery and I have been told of the risks, including bronchitis, pneumonia, hoarseness or voice changes, cardiac irregularities, heart attack or death. 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. Do to otherwise may be life-threatening!

6. I realize the importance of providing true and accurate information about my health, especially concerning possible pregnancy, allergies, medications and history of drug or alcohol use. If I misinform my doctor I understand the consequences may be life-threatening or otherwise adversely affect the results of my surgery.

7. 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 slightly loose for some time after the wiring, and there is always some concern about airway obstruction. I agree to carry wire cutters with me at all times when my jaws are wired and to avoid the use of alcohol and other activities that may cause airway problems.

8. I certify that I have had an opportunity to read and fully understand this document and that all blanks were filled in prior to my signing this form. All my questions have been answered to my satisfaction and I am willing to undergo the proposed surgery. I also state that I speak, read and write English

CONSENT
By signing this consent form, I acknowledge that I have read it completely and understand the procedure to be performed, the risks, and the alternatives to surgery. I have had all my questions answered to my satisfaction. I was under no pressure to sign this form and have made a voluntary choice to proceed with surgery. I am fully aware that no guarantee or warranty can be made regarding the results of treatment.

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

Doctor's Signature
Date

Witness' Signature
Date