·ST. CATHARINES ORAL SURGERY·

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ORAL & MAXILLOFACIAL SURGEON

CONSENT FOR SURGERY AND ANESTHESIA

What you are being asked to sign is confirmation that we have discussed your proposed treatment and that you are aware of the expected benefits of the surgery, the risks that are associated with the procedure, and the expected consequences of not having the surgery.

Patient Name: _____

_____

This is my consent for Dr. _____ to perform the following procedure: _____

_____

_____

_____

☐ under local anesthesia ☐ nitrous oxide/oxygen sedation ☐ intravenous sedation ☐ general anaesthetic

THE FOLLOWING RISKS AND COMPLICATIONS ARE KNOWN TO BE ASSOCIATED WITH THESE PROCEDURES, AND INCLUDE BUT ARE NOT LIMITED TO:

1. Pain and swelling requiring several days of home recuperation.
2. Bleeding, bruising and/or infection which may require additional treatment.
3. Jaw stiffness that may persist for several days or weeks resulting in restricted mouth opening.
4. Injury to other teeth, fillings or crowns.
5. Injury to nerves which can lead to an altered degree of sensation or numbness of the lips, chin, teeth, gums or tongue on the operated side. This may last for several weeks or months, or in rare cases, may be permanent.
6. Stretching of the corners of the mouth resulting in cracking or bruising that may heal slowly.
7. Decision to leave a fragment of tooth when its removal could lead to extensive surgery.
8. An opening into the sinus of the upper jaw which may require further treatment.
9. Stretching or dislocation of the jaw joint.
10. Cracked or fractured jaw.
11. Dry socket.
12. Need for further surgery in the future.
13. Certain anesthetic risks which may include nausea and vomiting; allergic reaction to drugs; inflammation, bruising or infection at the site of injection or vein; respiratory and cardiac complications requiring emergency resuscitation.
14. Other complications specific to the procedure: _____

_____

FOR PATIENTS UNDERGOING SEDATION/GENERAL ANAESTHETIC:

1. I agree that I have not eaten anything, including liquids for a minimum of 6 hours prior to the planned procedure.
2. I will have a responsible adult to escort me home following surgery.

By signing below, I acknowledge that I have read the above and understood this form and that I voluntarily consent to the performance of the procedures described above.

_____ _____

Patient (or Parent/Guardian) Date

_____ _____

Oral and Maxillofacial Surgeon Date

_____ _____

Witness Date