AOMSI CONSENT FORM

For A Safer Tomorrow

ORAL AND MAXILLOFACIAL SURGERY

CONSENT FOR ORTHOGNATHIC SURGERY

Patient's Name _____ Age /sex _____ Date _____

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

Orthognathic surgery is being planned for you, 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.

1. I hereby authorize Dr._____and staff to treat the condition described as:_____
   _____

2. The surgical procedure planned to treat the above condition has been explained to me and I understand the nature of the treatment to be:_____
   _____

3. I have been informed of possible alternative forms of treatment (if any), including:_____
   _____

4. My doctor has explained to me that there are certain potential risks and side effects of the surgery planned, 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. I have been informed about the opportunity for blood donation before surgery so that, my own blood may be transfused back to me (auto transfusion) if necessary.
   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. Possible Hematoma at injection site .

G. Diminished sense of smell (anosmia) in the upper jaw surgery.

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 certain cosmetic changes may not be totally predictable. There may also be changes in speech patterns which may require additional treatment.

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. Loss of taste sensation in tongue and palate . 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 muscles of facial expression.

K. Scarring from external skin incisions if certain rigid fixation methods are used.

L. Malfunctioning or breakage of hard ware. 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 marrow space between teeth, there is the possibility of devitalization of those teeth which may require later root canal procedures, and may result in the loss of these teeth.

N Fracture of the maxilla and mandible due to improper mobilization or incomplete osteotomies

O. In upper jaw surgery, the sinus will be affected for several weeks, and there may bleeding from nose in postoperative period. There may be a need for further sinus surgery to remedy any lingering problems**.**

P. Post-operative infection which may cause loss of adjacent bone and/or teeth and which may require additional treatment for a prolonged period of time.

Q Change in position of the 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 these symptoms after surgery.

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

S. 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.

T. Hypernasality of voice due to swelling of nasal mucosa in immediate post operative period. Diffculty in swallowing and speech in cases of cleft patients due to velopharyngeal incompetence**.**

U I consent to being photographed (head and neck region only) before and After surgery and during the operation to be performed. .

These photographs may be used for medical, scientific or educational purposes, provided my name is not revealed by the pictures

V Airway compromise and fall back of tongue in cases of set back surgeries of mandible.

5. **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) FOR EIGHT (8) HOURS PRIOR TO AND (8) HOURS AFTER SURGERY . **TO DO 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.

ABOUT WIRING OF TEETH

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, compromised nutrition 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 nausea or airway problems.

Signature ----------

INFORMATION FOR FEMALE PATIENTS

I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

Signature ----------

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. The fee for services has been explained to me and is satisfactory and I understand there is no warranty or guarantee as to the result and/or cure and that my condition may return or become worse. I certify that I speak, read and write English.

Patients (or guardian`s) signature & Date

Witness signature:

1.

2.

Doctor`s signature