Consent for Biopsy Procedure

Patient Name: _____ Date: _____

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

You have the right to be given pertinent information about your proposed surgery so that you may make an informed decision or treatment. 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. The planned procedure will be an **Excisional Biopsy** *(in which the surgeon will remove the suspected tissue totally. If the biopsy report is suspicious, it may be necessary to return to the area to remove additional tissues to obtain a margin of safety)* and/or an **Incisional Biopsy** *(in which the surgeon will remove only enough tissue to get a good sample, leaving the remaining tissue behind. This is usually done when the lesion is large, it is suspected to be benign, or the removal of all of it at this time would be unnecessarily difficult. However, if the biopsy report is suspicious, the entire lesion may have to be removed later).*

_____2. 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 to weeks. Sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).

f. Reactions to medications, anesthetic, sutures, etc.

g. Injury to sensory nerve branches in the area of the biopsy which may result in pain, tingling or a 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 cavity above the upper back teeth) which may require additional treatment.

j. There is always a possibility of the lesion recurring in the same area, even when it appears to be totally removed.

k. Other:_____

_____3. It has been explained to me that during the course of surgery unforeseen conditions may be revealed which may necessitate extension of the original procedure or a different procedure from that planned. I authorize my doctor to perform such additional procedures as are necessary in the exercise of professional judgment.

_____4. I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general or intravenous anesthetic. I consent to the administration of **local / nitrous oxide and/or IV anesthesia**.

_____ 5. I am aware that local anesthesia has potential risks and complications; swelling, bleeding, bruising and possible nerve injury, usually temporary causing prolonged numbness and discomfort in the injected areas.

_____6. 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 which, if not done, may allow progression of my condition to a state requiring additional care of further surgery, or the lesions may recur and become a threat to my health. I agree to comply by having regular scheduled exams as instructed by my surgeon and to notify this office if I suspect a change in my condition.

_____7. I agree that I have been given verbal and written postoperative care instructions.

FEMALE PATIENTS ONLY:

_____ It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medications are completed.

I certify that I have had an opportunity to fully read the above consent and I understand the terms and words within, as well as any explanations made or referred to. I certify that all blanks or statements requiring insertion or completion were filled in and non-applicable paragraphs, if any, were stricken out before I signed. I also state that I speak, read, write and understand English. I agree to the taking of photographs/video for documentation and educational purposes.

My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient *(or Legal Guardian)* Signature **Date**

Witness Signature Date

Doctor Signature Date