Consent for Biopsy

Patient's Name _____ _____
DATE

It is essential that the surgical patient understand why his/her surgical procedure has been recommended, how it is performed and the major risks and complications that can accompany the procedure.

PLEASE READ AND INITIAL EACH PARAGRAPH BELOW. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING OR SIGNING THIS FORM.

Your doctor has observed an area in your mouth, bone or skin that needs further evaluation. This is done by the surgical removal of either a portion of or the entire area and having a pathologist make a microscopic diagnosis.

The area to be sampled is _____

Usually these are benign, but sometimes they are of concern. As a result, you may need additional surgery at a later date.

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

_____

As with any surgery, you may experience

_____ 1. Postoperative pain and swelling.

_____ 2. Prolonged bleeding, which may require further treatment.

_____ 3. Stretching or drying of the corners of your mouth.

_____ 4. Difficulty in opening your mouth.

_____ 5. Postoperative infection, requiring antibiotics or additional surgery.

_____ 6. Reactions to medications, sutures, anesthetics, etc.

_____ 7. Injury to nerves in the area of surgery, which may cause a numbness, tingling, or burning sensation to the lip, chin, tongue, gums, teeth or cheek, including loss of taste. This usually resolves within a few weeks or months but occasionally may be permanent.

_____ 8. Sinus opening, which may require surgical closure.

_____ 9. Possibility of a recurrence of the lesion even though it initially appeared to be completely removed.

_____ 10. During the course of treatment unforeseen conditions may be observed, which may require extending the area or even a different surgery than originally planned. I authorize my doctor to perform these additional procedures as are necessary using his/her professional judgment.

_____ 11. Other _____

_____ 12. I understand that I may need long-term follow-up care and will be given appointments for this care. This may occur even if the biopsy report is benign. I understand the importance of this

care, and that if not done, may lead to recurrence or progression of my condition requiring additional surgery and may be dangerous to my health or be fatal. I agree to return for my scheduled appointments and to notify this office if I observe a change in my condition.

_____ 13. I realize that despite all precautions that may be taken to avoid complications, there can be no guarantee as to the result of the proposed treatment.

_____ 14. I understand the importance of providing accurate information about my health history, especially concerning possible pregnancy, allergies, use of medications and history of drug or alcohol use. If I misinform my doctor, I understand the consequences may be life-threatening or adversely affect the results of my surgery.

_____ 15. I have been advised of my option for a second opinion from another doctor regarding the proposed treatment.

INFORMATION FOR FEMALE PATIENTS

_____ I have informed my doctor about my possible 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 mechanical 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.

CONSENT FOR PROCEDURE

I have had an opportunity to ask questions and I certify that

_____ 16. All of my questions regarding the procedure have been answered to my satisfaction, and I wish to proceed with the procedure.

_____ 17. The anesthetic for my procedure has been discussed with me, and I have signed a “Consent for Anesthesia.”

_____ 18. I speak, read and write English and understand all of the paragraphs of this Consent.

_____ 19. All blanks on this Consent were filled in prior to my reading and initialing.

_____ 20. I give my consent for this biopsy, and am aware that no guarantee can be made as to the outcome.

_____ 21 **Please note: You will be billed separately for pathology laboratory services.**

PATIENT’S/LEGAL GUARDIAN’S SIGNATURE	DATE
DOCTOR’S SIGNATURE	DATE
WITNESS’ SIGNATURE	DATE