CONSENT FOR FACIAL RECONSTRUCTION SURGERY

_____

Patient's Name Date

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

_____ 1. I authorize Dr. _____ and his/her authorized associates to treat my condition diagnosed as: _____
_____
_____
_____

_____ 2. The procedure(s) necessary to treat the condition(s) noted above has/have been explained to me, and I understand it/them to be:
_____
_____

_____ 3. Other options and alternatives to this procedure include no treatment at all, or: _____
I understand those options and the benefits and risk of each.

_____ 4. The proposed treatment has been outlined for me in laymen's terms and possible complications and side effects have been discussed, including (but not limited to):

_____ A. Post-operative swelling, discomfort, bruising, bleeding, hematoma (blood clot), wound infection, and limitation of function, any of which may require further care. Wound infection that does not respond well to normal antibiotic therapy may result in loss of the grafted bone.

_____ B. Adverse or allergic reactions to medications or anesthesia causing multiple side effects, some of which may be serious and require additional care or hospitalization.

_____ C. Change in jaw function after treatment; or secondary problems of the jaw joint (TMJ) which may be prolonged, or even permanent, and which may require future treatment. Pre-existing TMJ disorders are more likely to worsen after surgery.

_____ D. Scarring either inside or outside the mouth, depending on the nature and locations of certain incisions required in treatment.

_____ E. Facial muscle weakness, particularly of the tips, chin, tongue (including possible loss of taste sensation),

eyelids or other muscles of expression caused by injury to motor nerves in the area of trauma. Such weakness may be partial or total and may be temporary or permanent.