

INFORMED CONSENT: Biopsy

Alice Kelly

01/10/2018

Friday, June 30, 2023

Patient's Name

Date of Birth

Date of Surgery

PARKSIDE ORAL SURGERY AND IMPLANT CENTER Neeraja Nina Karwowska DDS, MD

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: Lesion in the mouth: left tongue

Procedure:

Incisional Biopsy Of Oral Tissue -Soft

MD

Inhalation Of Nitrous Oxide/Analgesia Anxiolysis

Non-Intravenous Conscious Sedation (Oral Midazolam)

Alternative options: No treatment, observation.

1. I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:

- Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials;
- Nerve injury, in the area of the biopsy, which may occur from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;
- Abnormal, enlarged, or cosmetically displeasing scars may occur within the skin and deeper tissue, sometimes requiring additional surgery. Some scarring may be permanent and always be visible;
- An opening may occur from the mouth into the nasal or sinus cavities;
- Loss of function and/or weakness of facial expression muscles possibly affecting my appearance. Such conditions may resolve over time, but in some cases may be permanent;
- Changes in speech, chewing, and swallowing. Such conditions may resolve over time, but in some cases may be permanent;

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- There is always a possibility that the lesion might come back, even when it appears to be totally removed.

2. I have elected to proceed with the anesthesia(s) indicated below.

☒ **Local Anesthesia** ☒ **Nitrous Oxide (laughing gas)**
☒ **Non-Intravenous Conscious Sedation (Oral Midazolam)**
☐ **Moderate Intravenous Sedation** ☐ **Deep Sedation (General Anesthesia)**

I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

- Allergic or adverse reactions to medications or materials;
- Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed. Usually the numbness or pain goes away, but in some cases, it may be permanent;
- Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have an awareness of some or all events of the surgical procedure after it is over;
- Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death;
- Sore throat or hoarseness if a breathing tube is used.

3. I have been informed of and understand that follow up visits or care, additional evaluation, treatment or surgery, and/or hospitalization may be needed.

- I have been informed that my tissue sample will be sent to an Oral and Maxillofacial Pathology Laboratory to process and diagnose. I expect to receive an additional statement from this facility for this service. I understand that Parkside Oral Surgery will forward my medical insurance to the lab for billing. Parkside Oral Surgery is not responsible for any authorizations or network participation between my insurance and the lab.
- With every biopsy, treatment depends on the results of the tissue diagnosis. Further treatment, including additional surgery, may be necessary and will be reviewed with your treating surgeon. If bone tissue is removed, healing may take longer, and the biopsy result(s) will take longer to process.

4. Patient's Responsibilities:

- I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).
- I understand the use of tobacco and alcohol is detrimental to the success of my treatment.

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- Even if the biopsy report is negative, I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise or there is a change in my condition, and complete care. I understand that continued care and/or treatment may be necessary for an extended period of time. I will inform my doctor of any post-operative problems as they arise. My failure to comply could make it difficult for the doctor to determine if more treatment is needed or if the lesion returns, which could be a threat to my health.
- I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.
- If I am sedated or under general anesthesia during the procedure, I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

X

Signature Alice Kelly Parent/Guardian

Date

Relationship

Witness' Signature (office will provide)

Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understand what I have explained.

Neeraja Nina Karwowska DDS, MD

Date