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Board Certified
American Board of Plastic Surgery
American Board of Oral & Maxillofacial Surgery

CONSENT FOR ORTHOGNATHIC SURGERY

Patient's Name Date

Please initial each paragraph 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. Punjabi 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 my surgery, 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 advised of the opportunity for blood donation before surgery so that my own blood may be given back to me (autotransfusion) 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.
_____ G. Diminished sense of smell (if upper jaw surgery is done).
_____ 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 that may require additional treatment.

_____ I. Loss of feeling, pain or a tingling numbness in my chin, lips, tongue (including possible loss of taste), gums, or teeth that occurs in a significant number of patients. 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. 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 that may require later root canal procedures, and may result in the loss of those teeth.
_____ N. In upper jaw surgery, the sinus will be affected for several weeks, and there may be a need for further sinus surgery to remedy any lingering problems.
_____ O. 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.
_____ P. Change in position of the jaw joints (TMJ) that 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.
_____ Q. Stretching of the corners of the mouth with resulting discomfort and slow healing.
_____ R. 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.

_____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 **SIX (6) HOURS** PRIOR TO MY ANESTHETIC. **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.

_____7. 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, 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.

INFORMATION FOR FEMALE PATIENTS

_____1. 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.

CONSENT

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. I am fully aware that no guarantee or warranty can be made regarding the results of treatment. I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature Date

Anil P. Punjabi, M.D, D.D.S. Date

Witness' Signature Date

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