CONSENT FOR SINUS (CALDWELL-LUC) SURGERY

Patient's Name Date

Please initial each paragraph after reading. If you have any questions about your proposed treatment, please ask your doctor BEFORE initialing or signing this form.

This information about your proposed operation is offered so that you are able to make the decision as to whether to proceed. Your signature will confirm that you understand the nature of your proposed treatment, the known material risks associated with it and the possible alternative treatments.

_____1. Dr. _____has informed me of my diagnosis (condition) which is described as: _____

_____2. The surgical procedure proposed to treat the above condition has been explained to me and I understand it to be:_____ _____

_____3. I have been informed of possible alternative forms of treatment for my condition (if any) including: _____ _____

I understand that these and other forms of treatment, including no treatment at all, are choices I have, and the risks of those choices have been explained to me.

_____4. I have been told that incisions will be placed inside my mouth on the upper jaw in order to enter my sinus through a bony "window" which will be created. I am aware of the location of the incision(s) including the possibility that other incisions may be made inside my mouth or nose to improve sinus drainage and to allow packing material to be placed temporarily after the surgery.

_____5. I have been told that all or portions of the sinus lining may be removed and that biopsy procedures may be done for microscopic pathologic diagnosis.

RISKS OF SINUS OPERATIONS

_____6. My doctor has explained to me that there are certain inherent risks and side effects in any surgical procedure and, in this specific instance, such risks include, but are not limited to:

_____ A. Post-operative discomfort and swelling that may require several days of at-home recovery. If nasal packing is used it will temporarily make breathing more difficult, cause some discomfort, cause unpleasant odors and be somewhat unsightly. Usually a nasal bandage will be applied for a temporary period to absorb drainage.

_____ B. Prolonged or heavy bleeding from mouth or nose that may require additional treatment.

_____ C. Injury or damage to adjacent tooth roots, possibly requiring further root canal therapy; and occasionally the loss of an injured tooth.

_____ D. Post-operative infection of sinus or nose that may require antibiotics (including in-dwelling catheter therapy), additional treatment, or repeat surgery.

_____ E. Stretching of the corners of the mouth that may cause cracking and bruising and which may heal slowly.

_____ F. Some chance of restricted mouth opening and chewing ability for several days after surgery.

_____ G. Possible recurring symptoms of sinusitis requiring certain medications and longer recovery time.

_____ H. Possible injury to sensory nerve branches in the cheek or gums that may result in numbness, pain, tingling or other altered sensation in the face, lower eyelid area, cheek, lip, gums, teeth or nose. These symptoms may persist for several days, weeks, months or, in rare instances, may be permanent.

_____ I. Possible oral-antral fistula - an opening from the sinus to the mouth - which may require additional medical or surgical treatment.

_____ J. Orbital complications including swelling, infection and abscess formation, visual complications, cavernous sinus thrombosis and cranial complications including abscess, meningitis, and blindness.

_____ K. Bony infection which may be prolonged and require long-term antibiotic therapy.

_____ L. Excessive mucosal discharge from the nose for sometime after surgery.

_____7. I agree to faithfully follow post-operative instructions, and to especially refrain from nose blowing, sucking through a straw, heavy exertion and smoking until recovered from surgery.

_____8. **ANESTHESIA**

The anesthetic I have chosen for my surgery is:

❒ Local Anesthesia
❒ Local Anesthesia with Oral Premedication
❒ Local Anesthesia with Nitrous Oxide
❒ Local Anesthesia with Intravenous Sedation
❒ General Anesthesia

_____9. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, and allergic reactions. There may be inflammation (phlebitis) at the site of intravenous injection which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

_____10. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED:**

A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.

B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING!**

D. **However**, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

_____11. No guaranteed results have been offered or promised. I realize my doctor may discover conditions which may require different surgery from that which was planned. I give my permission for those other procedures that are advisable in the exercise of professional judgement to complete my surgery.

CONSENT

I have had an opportunity to have all my questions answered by my doctor, and I certify that I speak, read and write English. My signature below signifies that I understand the surgery and anesthetic that is proposed for me, together with the known risks and complications associated. I hereby give my consent for such surgery and for the anesthesia I have chosen.

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

Doctor's Signature Date

Witness' Signature Date