This form and your discussion with your child’s doctor are intended to help you make informed decisions about the proposed surgery. As a member of the treatment team, you have been informed of your child’s 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 is available to answer any questions you or your child may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternative options: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I have been informed of and understand the known risks related to this surgical procedure include but are not limited to:
   * Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to teeth or roots that may result in the need for tooth repair or loss, loose teeth, damage to dental appliances, retention of tooth structure, bone or foreign material in the body, cracking 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 or adverse reaction to medications or materials;
   * Nerve injury, 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 and/or require additional treatment
   * Separation of the palatal tissues(roof of mouth) and/or oral-nasal repair may occur resulting in a persistent opening between the mouth into the nasal and sinus cavities ;
   * Stunted facial growth (bones in the middle of the face may not grow correctly) resulting in a profile where the middle third of the face does not project as much as the lower jaw;
   * Change in bite (malocclusion) usually resulting in an under bite; and/or
   * Changes in speech patterns or speech development abnormalities, which may require speech therapy.

BONE GRAFT

The graft will be taken from (anatomic location) or will be banked bone or bone substitute:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The graft will be placed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand this graft involves additional potential risks, including but not limited to:

* + Nerve injury at the place the graft was taken from or where the graft is placed resulting in altered or loss of feeling, numbness, or pain in the lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;
  + Failure, loss, infection, or rejection of the graft or membranes used to contain the graft;
  + An opening may occur from the mouth into the nasal or sinus cavities;
  + If I have elected a banked bone or bone substitute graft, I understand there is a rare chance of disease spread from the processed bone.

1. We have elected to proceed with the anesthesia(s) indicated below.

\_\_\_\_\_\_ Local Anesthesia

\_\_\_\_\_\_ Mild Sedation

­­

\_\_\_\_\_\_ Moderate Sedation

\_\_\_\_\_\_ Deep Sedation (General Anesthesia)

I have been informed of and understand the known 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 completed.
* 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.

If we have elected Mild, Moderate, or Deep Sedation (General Anesthesia), my child has not had anything to eat or drink for at least six (6) hours prior to his/her procedure. I understand that doing otherwise may be life-threatening. As instructed, he/she has taken their regular medications and/or any medicine given to me by my child’s doctor using only small sips of water. My child will be accompanied by a responsible adult to drive them to and from the doctor’s office and he/she will stay with the child after the procedure until they have recovered sufficiently to care for themselves. I understand the drugs given to my child for this procedure may not wear off for 24 hours. During my child’s recovery from anesthesia, I agree they will not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

1. I further understand that the use of protective stabilization may be become necessary in the interest of safety for the patient, staff, and/or guardian. Protective stabilization may include: mouth prop, the use of a stabilization board, fabric wraps, Velcro® materials, or being restrained by a parent, guardian, and/or dental staff member. Possible risks and complications that have been explained to me include: distress and/or chance of injury including bruising or skin abrasion.
2. The surgical results may not match expectations and may vary between individuals. Future additional procedures may be necessary to achieve desirable results. I have been informed of and understand that follow up visits or care, additional evaluation, treatment or surgery, including hospitalization, may be needed.
3. If a cleft or obturator prosthesis is worn, there may be an inability to wear it for an extended period or a need to re-make it after healing is complete.
4. Patient/Guardian Responsibilities

I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, you have provided your child’s 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 and agree to have my child follow all instructions provided to us 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, and complete care. I will inform my child’s doctor of any post-operative problems as they arise. Our failure to comply could result in complications or less than optimal results.

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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient or Legal Representative Name/Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Witness to Patient Signature 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 understands what I have explained.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature Date