GREAT • LAKES
ORAL & MAXILLOFACIAL
SURGERY CENTRE

1825 MANNING ROAD • RR#1 • TECUMSEH • ON • N8N2L9
PHONE 519.979.7227 FAX 519.979.1956

INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA

1. This is my consent for Dr. Michael Laschuk and/or any oral and maxillofacial surgeon who is working with him to perform the following treatment/procedure/surgery _____
As previously explained to me or other procedures deemed necessary or advisable as necessary to complete the planned operation.

2. I understand the nature of the procedure/surgery and that the purpose of the procedure/surgery is to treat and help correct my diseased oral/maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to, the following: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental caries, malocclusion, pathologic fracture of jaw, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment if any.

3. Dr. Michael Laschuk has explained to me that there are certain normal sequellae (after-effects) inherent in any oral surgery treatment plan or procedure and that in this specific instance such sequellae may include one, none or all of the following:
-Postoperative discomfort and swelling that may necessitate several days of home recuperation.
-Postoperative bleeding that may be prolonged and require treatment.
-Injury to adjacent teeth and fillings.
-Postoperative infection requiring additional treatment.
-Stretching of the corners of the mouth with resultant cracking and bruising.
-Restricted mouth opening for several days or weeks.
-Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
-Bruising of skin and gums.
-Delayed healing with accompanying pain (dry socket).

4. There is also the remote risk of complications with this procedure/surgery. They include but are not limited to:
-Breakage of the jaw.
-Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persists for several weeks, months or in the rare instance, permanently.
-Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

5. I consent to the administration of such local anesthesia, intravenous sedation and/or general anesthesia as deemed necessary by Dr. Cameron Walker and/or his designated assistants to accomplish the proposed procedure.

6. I agree and understand I am not to have and/or have had anything to eat or drink for 8 hours before my surgery. Except medications as directed by Dr. Michael Laschuk.

7. Depending on their strength, certain medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automo-bile or hazardous devices, or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. If intravenous sedation or general anesthesia is given I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me and accompany me home after my discharge from surgery.

8 .I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general anesthetic or intravenous sedation.

9. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable including, in case of emergency, transport to hospital.

10. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful and that a worsening of my condition would occur sooner without the recommended treatment.

11. I have had an opportunity to discuss with Dr. Michael Laschuk my past medical and health history including any serious problems and/or injuries.

12. I agree to cooperate completely with the recommendations of Dr. Michael Laschuk while I am under his care, realizing that any lack of same could result in a less than optimum result and I agree to attend post-operative assessment appointments when necessary.
I certify that I have had an opportunity to read and fully understand the terms and words within the above consent to the operation and the explanation referred to are made and that all blanks or statement requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed. I also state I read and write english/french.

_____	_____	_____
Signature of witness	Patient signature (or Guardian)	Date
_____	_____	
Print name of witness	Print name of Patient (or Guardian)	

_____
Address of witness

I have had the opportunity to fully discuss with the patient the nature of the procedure/surgery and the inherent risks.

_____	_____
Doctor Signature	Date