CONSENT FOR BIOPSY PROCEDURE

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Patient's Name Date

During your initial consultation we discussed your need for biopsy, steps involved, its purpose, benefits, and the possible complications/risks as well as alternatives. We obtained your verbal consent to undergo this procedure**. Please initial each paragraph after reading, if you have any questions please ask your periodontist <u>before</u> initialing and signing on the last page.**

______***1. Diagnosis.*** After careful oral examination my periodontist has informed me of an "abnormal" tissue***.*** When an "abnormal" soft or hard tissue is noted, a biopsy may be recommended. A biopsy is a surgical procedure whereby a sample of tissue is taken for microscopic study to determine if it is normal. This will aid in establishing a definitive diagnosis; i.e. benign or malignant. Other medical/dental professionals will perform the diagnostic studies related to my biopsy. Final microscopic diagnosis will aid us in providing appropriate treatment or referrals.

In your case, the area of concern is: ____

______***2. Recommended Treatment.***

☐ A. <u>Excisional biopsy</u>: Remove the suspected tissue entirely. If the biopsy report indicates definitive disease, more tissue may need to be removed to get a margin of safety,

OR

☐ B. <u>Incisional biopsy</u>: Remove only enough tissue to get a good sample, leaving the remaining tissue behind (this is usually done when the lesion is large, or the removal of all of it at this time may be unnecessary). If the biopsy report indicates definitive disease, the entire lesion may have to be removed later.

______***3. Expected Benefits:*** Establishing proper diagnosis will aid in providing appropriate treatment and referrals as needed. Additionally, it will help in recognizing abnormalities, cancerous lesions, and systemic diseases that can also manifest themselves in the head and neck region.

______***4. Principal Risks and Complications.*** I understand that a biopsy requires a cut(s) in my mouth or on the skin that will need stitches, and sometimes the removal of bone tissue. I understand that complications may result from the biopsy surgery, drugs, or anesthetics. These complications include, but are not limited to:

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

B. If bone tissue is removed, healing may take longer, some complications may be more likely (for example, bleeding), and the biopsy report may take longer due to special processing requirement.

C. Post-surgical infection, bleeding, swelling, pain, facial discoloration (bruising). Local anesthetic injection may cause allergic reaction, temporary or permanent injury to nerves and/or blood vessels.

D. During surgery it may be impossible to avoid touching, moving, stretching, or injuring the nerves in my jaw that control sensations and function. This can lead to transient (usually this disappears slowly over several weeks or months) but on occasion permanent numbness, itching, burning, pain or tingling of the jaw, teeth, gums, tongue (including the possibility of loss of taste sensation), lip, chin, cheek, or in areas of the skin of the face.

E. Fracture of the jaws, fracture of the tooth/teeth during surgery. Loss or injury to adjacent teeth and soft tissue, loss or loosening of dental restorations, swallowing of a tooth or fragments of a tooth, accidental swallowing/aspiration of teeth, restorations and instruments.

F. Jaw joint injuries, pain or muscle spasm/stiffness cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, and transient (on rare occasion permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods or shrinkage of the gum upon healing. The exact duration of any complication cannot be determined, and they may be irreversible.

______*5.* As the success of surgical procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications (including over-the-counter medications such as Aspirin, nutritional supplements and herbs that I may be taking), I have reported to my periodontist any present or prior drug reactions, allergies, diseases, symptoms, habits, or conditions, head and neck radiation therapy, use of bisphosphonates (Zometa, Aredia, Boniva, Fosamax, and Actonel) for osteoporosis or other conditions.

______***6. Alternatives to Suggested Treatment.*** Alternatives to biopsy include:

(1) No treatment (I understand that not seeking treatment will limit diagnostic tools of my periodontist to provide the appropriate diagnosis, treatment or referrals and possible worsening of my condition).

______***7. Necessary Follow-up Care and Self-Care.*** I understand that I may need to come back to see my periodontist for follow-up for a long time, even if the biopsy report is benign or shows no cancer. I understand that if I need to and do not return for follow-up, my condition may get to a point where I might need more care or more surgery, or the lesion might come back and be a threat to my health. I agree to schedule exams as instructed by my periodontist and report if I think there is a change in my condition. I may have to be referred to other health care professionals for additional treatments.

______ 8. ***Unforeseen Conditions.*** I understand that during the course of surgery, unforeseen conditions may be revealed, which may necessitate extension of the original procedure or a different procedure from that which was planned. I authorize my periodontist to perform such additional procedures as are necessary in the exercise of professional judgment.

______***9. No Warranty or Guarantee.*** No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences there can never be a certainty of success, despite the best of care. I understand, there is no method that will accurately predict or evaluate how the tissue will heal before the surgical procedure. There may be a need for a second surgery.

______**10.** ***Use of Records for Reimbursement and Publication Purposes.*** I authorize photos, video recordings, x-rays, slides, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry, educational use in lectures or publications and reimbursement purposes. My identity will never be revealed to the general public.

______***11. Females only.*** Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills), which can result in pregnancy. Therefore, I understand that I will need to take extra precautions and use some additional form of birth control when taking antibiotics. Furthermore, I have informed my periodontist of my pregnancy and/or nursing status.

PATIENT CONSENT

I have been fully informed of the nature, risks and benefits of the biopsy procedure, the alternative treatments available, and the necessity for follow-up care and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the biopsy as presented to me during my consultation and as described in this document above. I also consent to additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist. I have given a complete and truthful medical history, including all medications, drug use, allergies, pregnancy and etc. I certify that I have read and fully understand this document

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Patient's Signature (or patient's guardian) Date

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Witness Signature Date