CONSENT FOR INCISION AND DRAINAGE

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Patient's Name Today's Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR *BEFORE* INITIALING.

My condition has been explained to me as an **abscess** – an advanced infection that has caused a localized collection of infected fluids. The primary treatment of an abscess is to drain the area – called "Incision and Drainage" – to assist healing and to allow other treatment such as antibiotics, etc. to work better.

____ 1. The procedure(s) necessary to treat my condition(s) has/have been explained to me and I understand the nature of the treatment to be:

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____ 2. I have been informed of possible alternate methods of treatment (if any) including:

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

____ 3. My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and, in this specific instance, they include, but are not limited to:

____A. Post-operative discomfort and swelling that may require several days of at home recovery.

____B. Infections are often difficult to cure and may require additional (sometimes complex and prolonged) treatment even after the incision and drainage procedure.

____C. Prolonged or heavy bleeding that may require additional treatment.

____D. Injury or damage to structures or tissues (blood vessels, nerves, salivary glands or ducts, bone, etc.) that lie deep to the skin or gum/cheek mucosa and cannot be readily identified.

____E. Injury to sensory nerves in the area (undetectable by any exact means) that may result in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, teeth, gums or tongue (including possible loss of taste sensation), and which may persist for several weeks or months, or in rare cases, may be permanent.

____F. More rarely, motor nerves in the area of the incision may be affected, which may result in diminished function of muscles of facial expression.

____G. Placement of drains (rubber or fabric) that are often sutured to place and require removal. after several days. Such drains may add to discomfort and interfere with normal function.
____H. Stretching of the corners of the mouth that may cause cracking or bruising, and may heal slowly.
____I. Allergic reactions (previously unknown) to any medications used in treatment.
____J. Restricted mouth opening during healing, sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
____K. If the approach to the abscess necessitates a skin incision, there will be some evidence of scarring that will be permanent. Such scarring may sometimes be repaired by additional plastic surgery.

____ 4. During the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

____ 5. The anesthetic I have chosen for my surgery is:
_____ ☐ Local Anesthesia
_____ ☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
_____ ☐ Local Anesthesia with Oral Premedication
_____ ☐ Local Anesthesia with Intravenous Sedation

____ 6. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation (phlebitis) at the site of an intravenous injection that may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and although considered safe, does carry the rare risks of heart irregularities, heart attack, stroke, brain damage or other very serious medical consequences.

____7. **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**. Unless a qualified driver is present before surgery, the appointment will be canceled!**
B. During recovery time you should not drive, operate complicated machinery or devices, or make important business decisions.
C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE **NOTHING** TO EAT OR DRINK **FOR 6 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.**

____ 8. It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed. I understand that the infection could worsen, necessitating hospitalization for continued treatment and/or further surgical procedures to eliminate this infection.

I have read and fully understand this consent for surgery, and have had all questions answered prior to my initials or signature.

Surgical time out _____

Please ask your doctor if you have questions concerning this consent.

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

Doctor's Signature Date

Witness' Signature Date

Print Witness' Name and Address

Unless sooner terminated in writing, this consent shall remain in force for 60 days from the date it is signed by the Patient. A facsimile transmission, and/or an electronic scanned transmission, shall constitute an original. 05/2012