AUBURN NY ORAL SURGERY

Sandeep Singla DDS, MD
Rinil Patel DDS
Edward Woodbine DDS
www.auburnnyoralsurgery.com
183 Genesse Street
Auburn, NY 13021
Tel: (315) 253-7384
Fax: (315) 253-7426

CONSENT FOR SINUS (CALDWELL-LUC) SURGERY

Patient's Name _____ Date _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have this procedure or not after knowing the risks and benefits.

My diagnosis is: _____
My Planned Treatment is: _____
Alternative treatment: methods include: _____

_____1. I have been told that incisions will be placed inside my mouth on the upper jaw in order to enter my sinus. A bony "window" will be made into the sinus. I understand where the incision(s) will be made, and understand it is possible 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.

_____2. I have been told that all or portions of the sinus lining may be taken out and that biopsy procedures may be done to help diagnose my disease.

____3. All surgeries have some risks. They include the following and others:

- _____ A. Post-operative pain and swelling that may require several days of at-home recovery. If nasal packing is used it will make breathing more difficult for a while, cause some pain, cause unpleasant odors and be somewhat unsightly. Usually a nasal bandage will be applied for a while to absorb drainage.
- _____ B. Prolonged or heavy bleeding from mouth or nose that may need more treatment.
- _____ C. Injury or damage to adjacent tooth roots, possibly needing further root canal therapy; or even the loss of another tooth.
- _____ D. Post-operative infection of sinus or nose that may need medication, more 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 limited mouth opening and chewing ability for several days after surgery.
- _____ G. Possible recurring symptoms of sinusitis needing medications and longer recovery time.

AUBURN NY ORAL SURGERY

Sandeep Singla DDS, MD
Rinil Patel DDS
Edward Woodbine DDS
www.auburnnyoralsurgery.com
183 Genesse Street
Auburn, NY 13021
Tel: (315) 253-7384
Fax: (315) 253-7426

CONSENT FOR SINUS (CALDWELL-LUC) SURGERY CONT…

_____H. Numbness, pain, or changed feelings in the face, lower eyelid area, cheek, teeth, gums, lip or nose. This is due to the closeness to the sensory nerve which can be injured or damaged. Usually the numbness or pain goes away, but in some cases, it may be permanent.

_____ I. Possible oral-antral fistula - an opening from the sinus into the mouth that may need more 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 last a long time and need long-term medications.

_____ L. A large amount of discharge from the nose for some time after surgery.

_____4. I agree to faithfully follow post-operative instructions. I will not blow my nose, suck through a straw, smoke, or do heavy work until I have recovered from surgery.

INFORMATION FOR FEMALE PATIENTS

_____5. I have told my doctor that I use birth control pills. My doctor has told me that some antibiotics and other medications may reduce the preventive effect of birth control pills, and I could conceive and become pregnant. I agree to discuss with my personal doctor using other forms of birth control during my treatment, and to continue those methods until my personal doctor says that I can stop them and use only oral birth control pills.

ANESTHESIA

I have had the opportunity to speak with Dr. _____ about my options for anesthesia. These options include Local Anesthesia, Nitrous Oxide/Oxygen Analgesia with Local Anesthesia, Oral Medication with Local Anesthesia, Intravenous Sedation, or Deep Sedation/General Anesthesia. After this discussion, I have chosen to have _____ as my anesthesia. I understand the risks and potential complications of anesthesia to include:

_____6. Discomfort, swelling or bruising where the drugs are placed into a vein.

_____7. Vein irritation, called phlebitis, where the drugs are placed into a vein. Sometimes this may grow to a level of discomfort or disability where it may be difficult to move my arm or hand. Sometimes medication or other treatment may be needed.

_____8. Nerves travel next to the blood vessels where the drugs are placed into a vein. If the needle hits a nerve or if drugs or fluid leaks out of the vessel around a nerve, I may have numbness or pain in the nerve where it runs along the arm. Usually the numbness or pain goes away, but in some cases, it may be permanent.

_____9. Allergic reactions (previously unknown) to any of the medications used.

AUBURN NY ORAL SURGERY

Sandeep Singla DDS, MD
Rinil Patel DDS
Edward Woodbine DDS
www.auburnnyoralsurgery.com
183 Genesse Street
Auburn, NY 13021
Tel: (315) 253-7384
Fax: (315) 253-7426

CONSENT FOR SINUS (CALDWELL-LUC) SURGERY CONT…

_____10. Nausea and vomiting, although not common, are possible unfortunate side effects. Bed rest, and sometimes medications, may be needed for relief.

____ 11. Conscious sedation and deep sedation/general anesthesia are serious medical procedures and, whether given in a hospital or office, carry the risk of brain damage, stroke, heart attack or death.

_____12. In situations where a breathing tube is used, I may have a sore throat, hoarseness or voice change.

MY OBLIGATIONS:

_____13. Because anesthetic or sedative medications (including oral premedication) cause drowsiness that lasts for some time, I MUST be accompanied by a responsible adult to drive me to and from surgery, and stay with me for several hours until I am recovered sufficiently to care for myself. Sometimes the effects of the drugs do not wear off for 24 hours.

_____14. During recovery time (normally 24 hours), I should not drive, operate complicated machinery or devices or make important decisions such as signing documents, etc.

_____15. I must have a completely empty stomach. It is vital that I have NOTHING TO EAT OR DRINK for **six (6) hours** prior to my treatment. TO DO OTHERWISE MAY BE LIFE-THREATENING.

_____16. **Unless instructed otherwise**, it is important that I take any regular medications (high blood pressure, antibiotics, etc.) or any medicines given to me by my surgeon **using only small sips of water**.

CONSENT

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to surgery and chosen anesthesia. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

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

Doctor's Signature Date

Witness' Signature Date