Informed Consent
For
Oral & Maxillofacial Surgery
Dentoalveolar

Patient Name: _____ **Age:** _____ **HC#:** _____

This is my consent for **Dr. Bourget** to perform the following procedure(s):

_____
and such other additional or alternative procedures as may be found immediately necessary during treatment. I also consent to the use of local anesthetics, sedation, or general anesthesia for the purpose of this treatment.

The nature and the purpose of the procedure(s), the potential risks or complications involved, and possible alternative treatments have all been explained to me. These risks include, but are not limited to:

1) Pain and swelling
2) Bleeding and/or infection (either may require additional or urgent treatment)
3) Limited jaw opening, including aggravation of TMJ (jaw joint) pain
4) Injury to adjacent teeth or fillings which may require repair or loss of those teeth
5) Periodontal healing ("gum disease") or sensitivity problems with adjacent teeth
6) Decision to leave part of the tooth or root in the jaw
7) Perforation of the sinus above the upper teeth, possibly requiring corrective surgery
8) Permanent injury to nerves of the lower lip, chin, jaw, and/or tongue causing numbness and/or pain
9) Fracture of the jaw
10) Unusual or allergic reaction to medications given or prescribed (potentially life-threatening)
11) Need for further procedures

I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained. I agree to cooperate completely with the surgeon and his team and will follow the post-operative instructions to the best of my ability for my own comfort and safety. I have had the opportunity to ask questions concerning these procedures and all my questions have been answered satisfactorily.

IV SEDATION & GENERAL ANAESTHETIC PATIENTS: I understand I am not to operate any vehicle, hazardous device, sign legal documents, be left unattended or drink alcoholic beverages for at least 24 hours following surgery.
I am aware that a responsible adult must accompany me to and from the office. I know and agree to an appropriate period of fasting prior to the procedure as described in the pre-operative pamphlet or website or described by my surgeon.

If performed at the East Coast Medi Centre, this facility is a member of the Canadian Association for Accreditation of Ambulatory Surgery Facilities and as part of the requirements, your chart may be subject to a peer review for quality control by the Canadian Society for Accreditation of Ambulatory Surgery Facilities.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT EXPLANATIONS WERE GIVEN TO ME PRIOR TO TREATMENT.

_____ _____ _____
Patient or Consenting Adult (indicate relationship) Date **Doctor's Signature**

==========Complete Below Only If Instructed==========

I have reviewed the above procedure(s) and the risks today and have been given the opportunity to have further questions answered, and hereby authorize **Dr. Bourget** to perform procedure(s).

_____ _____ _____
Patient *or* Consenting Adult Date Doctor's Signature

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