



CONSENT FOR BIOPSY PROCEDURE

You have the right to be given information about your proposed treatment so that you may make an informed decision to have or not have treatment. A biopsy is a surgical procedure where a sample of tissue is taken for microscopic study to determine if it is normal. Only a biopsy can give a definitive oral cancer diagnosis. The type of biopsy typically used for diagnosing oral cancer is an incisional biopsy where a small piece of tissue is cut from an abnormal-looking area.

It is planned to:

- Take out all the suspected tissue. The sample will be submitted to a pathology lab for review. You are responsible for any additional pathology cost that will be applied. NOTE: If the biopsy report is suspicious for disease, Dr. Nakatani may need to take more tissues to get a margin of safety.
- Remove only enough tissue to get a good sample, leaving the rest behind. (This is usually done when the lesion is large, there is no cancer suspected, or the removal of all of it this time would be unnecessarily difficult.) However, if the biopsy report is suspicious for disease, the entire lesion may have to be removed later. The sample will be submitted to a pathology lab for review. You are responsible for any additional pathology cost that will be applied.

ALTERNATIVE TREATMENT METHOD(S), if any: _____

RISKS RELATED TO TREATMENT: 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. Dr. Nakatani has told me that there are certain risks that can occur with the surgery, including (but not limited to):

- Post-operative pain and swelling that may require several days of at home recuperation.
- Bleeding that is heavy or may last a long time that may need additional treatment.
- An infection after the procedure that may need more treatment.
- Stretching of the corners of the mouth that may cause cracking and bruising and which may heal slowly.
- A difficulty in opening the mouth for several days. This is sometimes due to swelling and muscle soreness and sometimes to stress on the jaw joints (TMJ).
- Reactions to medications, anesthetics, sutures, etc.
- Injury to the nerves in the area of the biopsy which may result in pain or a tingling or numb feeling in the lip, chin, tongue (including the possibility of loss of taste sensation), cheek, gums or teeth, or in areas of the skin of their face. Usually this disappears slowly over several weeks or months, but sometimes the effects may be permanent.
- 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 requirements.
- Opening into the sinus (a normal hollow place above the upper back teeth) needing more treatment.
- There is always a possibility that the lesions might come back in the same area, even when it appears to be totally removed.

CONSENT TO UNFORSEEN CONDITIONS: During treatment, unforeseen conditions may be discovered which call for a modification or change from the anticipated treatment plan. If Dr. Nakatani finds a different condition than expected and feels that a different surgery or more surgery needs to be done, I consent to the performance of such additional or alternative procedures as may seem necessary in the best judgment of Dr. Nakatani.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to the procedure. I give consent that my records may be used for educational use in lectures or publications provided that my identity is NOT revealed.

ANESTHESIA: A local anesthetic (numbness) will be used for the procedure. I understand that certain anesthesia risks include but are not limited to unfavorable reactions to anesthetic drugs, nausea, vomiting, allergic reaction, even cardiac arrest.

INITIAL _____

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I agree to diligently comply with any and all pre-operative and post-operative instructions given to me. I understand that I need to come back to see Dr. Nakatani for follow-up visits, even if the biopsy report shows no cancer. I understand that if I need to and don't return for my follow-up visits, 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 understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my treatment. It is my responsibility to timely seek attention should any undue circumstances occur post-operatively. I agree to report for post-operative care appointments following my treatment so that my healing may be monitored and so that Dr. Nakatani can evaluate and report on the outcome of my treatment upon completion of healing.

NO GUARANTEE OF TREATMENT: No guarantee or warranted results have been offered or promised. I realize that Dr. Nakatani may discover conditions that may require different surgery from that which was planned and I give my permission for those other procedures that are advisable in the exercise of the professional judgment to complete my surgery.

BISPHOSPHONATE DRUG RISKS: For patients who have taken drugs such as Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any surgical procedure involving bone.

SECOND OPINION: If any significant doubt or questionable understanding persists after receiving explanations and/or reading this document, I have been encouraged to seek another opinion from a dentist knowledgeable in the area of periodontal dentistry prior to completing my deliberation and decision.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of this procedure and have received answers to my satisfaction. I recognize that it is my responsibility to fully inform Dr. Nakatani of the condition of my health and any and all problems thereto. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and/or any results from the treatment rendered to me. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, (1) certifies that I have read and understand the entirety of this document and (2) I am freely giving my consent to authorize Dr. Nakatani and/or all associates involved in rendering any services he/she deems necessary and advisable to treatment of my dental conditions, including any anesthetic agents and medications.

Name of Patient (Please Print)

Signature of Patient or Legal Guardian

Date

As a part of this consent agreement, I give my personal pledge, as a healthcare professional dedicated to the well-being of my patients, to make every reasonable effort to assure that this patient receives the best possible care with the least possible risk.



Clifton E. Nakatani DDS MSD INC.

Witness