CONSENT FOR BIOPSY

Patient Name: _____Date: _____

I hereby authorize _____ and staff to perform the following procedure:_____

_____

and to administer the anesthesia I have chosen, which is: _____ Local Anesthesia ____ General Anesthesia

You have the right to pertinent information about your proposed surgery so you may make an informed decision as to whether or not to proceed. A biopsy is a surgical procedure whereby a sample of tissue is taken for microscopic study to determine if it is normal. It may require an incision and sutures, and an appropriate follow-up appointment will be arranged when needed.

The specimen will be submitted to an appropriate laboratory and reviewed by a qualified pathologist. You will receive separate billing for this service from the lab.

If you have questions with regard to the proposed treatment, please ask your doctor before signing this form.

I understand that the risks include but are not limited to:

- Post operative bleeding, swelling and/or discomfort.
- Post-operative infection.
- Injury to either feeling or motor nerves in the area of the biopsy which may leave a tingling or numb sensation on the lips, the gums or the side of the tongue, or may result in a change in muscle function. These are usually temporary in nature but, under rare circumstances, may be permanent.
- Recurrence of the lesion requiring further treatment including possible surgery.

I understand the risks associated with anesthesia, including cardiac arrest.

I have had the opportunity to have my questions answered, and give my consent to the procedure.

CONSENT

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

x _____

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

x _____

Doctor's Signature Date:

x _____

Witness's Signature Date: