Consent Form for Cleft Lip and Palate Surgery

Dental Hospital

Patient Information

Name.....Age..... years HN .....WARD.....

Scheduled procedure ..... Date .....

I, ..., hereby consent to receive treatment and/or undergo surgery by Dr..... and their medical team to address my condition or that of the individual under my guardianship using the following method(s): .....

This procedure can be explained in simple terms as follows: .....

.....

.....

1. I have received a detailed explanation from the attending dental/ medical team regarding the advantages, disadvantages, and procedural steps of the treatment. I have also been informed of alternative treatment options available, allowing me to make an informed decision. Furthermore, I understand that I have the right to refuse the proposed treatment.

2. Potential risk and complications

2.1 Allergic reactions to medications or substances used during surgery, such as antiseptics or antibiotics.

2.2 Adverse reactions to anesthesia, including allergic responses

2.3 Surgical complications, including:

2. 3. 1 Postoperative bleeding, which may obstruct the airway, necessitating the reinsertion of a breathing tube and possible return to the operating room to control bleeding.

2.3.2 Airway obstruction following cleft palate closure, as patients typically breathe more easily through an open palate. In such cases, temporary intubation may be required post-surgery.

2.3.3 Suture dehiscence, palatal fistula due to improper postoperative care, surgical site infections, and other post-surgical infections.

2.3.4 Hypertrophic scarring, which may require further treatment

2.3.5 Other potential complications : .....

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3. I acknowledge and accept that the dental/medical team cannot guarantee specific results or eliminate all risks, despite taking the utmost care and precautions.

4. The attending dental/ medical team is authorized to modify the treatment plan as necessary to achieve the best possible outcome. Should any treatment failure occur, I accept full responsibility for any associated costs.

5. Finalcial disclosure

The operating room nurses and benefits department staff have informed me of the treatment costs, including surgical fees, material and equipment costs, hospitalization fees,

anesthesia fees, and other essential expenses. Additionally, I have been advised about which expenses are covered and not covered under various healthcare benefits (e.g., universal healthcare coverage, government employee benefits, social security, and local government health schemes).

6. I fully understand and accept all of the above statements without any doubts and am prepared to undergo the prescribed treatment accordingly.

Signature: .....
(.....)
Treating Dentist

Signature: .....
(.....)
Patient / Authorized Representative
Relationship to the patient: .....

Signature: .....
(.....)
Witness

Signature: .....
(.....)
Witness

Date: ..... Time: .....

Note:

1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.