

# ENT & Audiology Center of Southlake

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## DISCLOSURE AND CONSENT

### FRENOPLASTY

You have the right, as a patient, to be informed about your condition and the recommended surgical procedure to be used so that you can make the decision whether or not to undergo the surgery after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

I voluntarily request my physician, \_\_\_\_\_, to treat my condition which has been explained to me as:

Ankyloglossia (Tongue Tie)

I understand that the following surgical procedure is planned for me and I voluntarily consent and authorize this procedure:

Frenoplasty

I understand that my physician may discover other or different conditions, which require additional or different procedures than are planned. I authorize my physician to perform such procedures, which are advisable in his/her professional judgment.

Just as there may be risks and hazards in continuing my present condition without treatment, there are risks and hazards related to the performance of the surgical procedure planned for me. I realize that common to surgical procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I also realize that the following risks and hazards may occur in connection with this procedure:

1. Inadequate mobilization of the tongue, with need for subsequent procedures.
2. Bleeding, scarring, or infection.
3. Injury to salivary ducts.

I have been given the opportunity to ask questions about my condition, risks of no treatment, the surgical procedure to be performed, and the risks and hazards involved, and I have sufficient information to give this informed consent. I certify that this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been completed, and that I understand its contents.

\_\_\_\_\_  
PATIENT'S NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PARTY)

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE OF SIGNATURE

\_\_\_\_\_  
DATE OF SURGERY

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