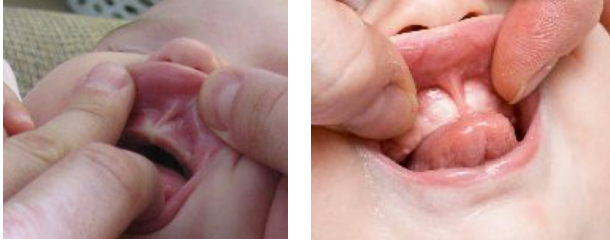


Informed Consent for Infant Oral Surgery

Lip-Tie Release



Tongue-Tie Revision



Prior to completing any oral care on your infant, we require your consent for treating your child. It is the philosophy of our office to provide children the highest quality of care with in a manner which is as pleasant and safe as possible. During treatment on small infants, it may be necessary for your infant to be swaddled or placed in a similar protective appliance to control undesirable movements. In some instances, there may be the need for Dr. Brewster to numb the surgical area using a small amount of local anesthetic and to provide adequate visibility and access to the surgical areas using a comfortable mouth prop.

Older infants may require some type of oral premedication, which if needed, will be discussed prior to having any child sedated. The purpose of all these procedures are to gain and maintain good oral health, primarily at this age, breastfeeding, reducing maternal discomfort and, in many instances, future problems that may be associated with lingual and or lip-ties.

Dr. Brewster anticipates good results, however, no guarantees as to the results are given. Laser treatment usually proceeds as planned; however, as in all areas of medicine, results cannot be guaranteed, nor can all consequences be anticipated. Post-surgical discomfort may be minimal or last as long as a week before our goals are met. Bleeding is always a rare possibility; however, we have not experienced any significant problems that would indicate any serious risks of the surgery. Not treating existing dental problems in children may result in continuing breastfeeding problems. Successful breastfeeding is our primary goal for today's surgery. Parents and guardians should understand recommended procedures, alternative options and anticipated results.

Surgery for tongue-tie and lip tie for infants in this office is completed using appropriate laser technology, which has proven safe for infants as well as all patients. Successful results of this Surgery is dependent on parents following carefully all post-operative recommendations for keeping the surgical sites from healing together, seeing their lactation consultant and, if indicated, a craniosacral therapist.

Acknowledgment of Informed Consent

I hereby acknowledge that I have been fully informed as to the treatment considerations. I have read and understand this form. I understand the advantages and disadvantages of treatment as well as alternative means of completing these procedures. My office has explained to you, the purpose of the surgery through a consultation involving oral discussions and written information. I have been given the opportunity to ask Dr. Brewster all questions I have about the proposed surgical treatment. All questions and concerns have been discussed. I give my free and voluntary, informed consent for treatment to be completed. By signing this consent, I indicate that I have the legal authority to grant this permission. I also agree to pay all fees and have given Dr. Brewster a complete medical history of my child.

Child _____
 (Print Child's Name)

Parent _____
 (Parent's or Guardian's Signature)

Today's Date _____

Lip and Tongue Frenectomy Informed Consent

LIP TIE A tight upper lip frenum attachment may compromise full lip flanging and appear as a tight, tense upper lip during nursing. This can result in a shallow latch during breastfeeding. Additionally, the tight upper lip may trap milk, resulting in constant contact of the milk to the front teeth. This can result in decalcification and dental decay can develop when the milk is not cleaned off of these areas. This same issue can occur with bottle-feeding. If the frenum attaches close to the ridge or into the palate a future diastema (gap between the teeth) can also occur.

TONGUE TIE A tight lower tongue frenum attachment may restrict the mobility of the tongue and appear as a cupping or heart shaped tongue when the tongue is elevated. This can result in an inability to get the tongue under the nipple to create a suction to draw out milk. Long term a tongue tie can result in speech problems and/or issues later with transferring food around the mouth for chewing.

SYMPTOMS Some babies can have ties and not be symptomatic. To know if the ties are a problem we ask two major questions: "Is the baby getting enough to eat?" and "Is nursing comfortable for the mother?" Symptoms can be as follows:

- Poor latch
- Slides off nipple or falls asleep while attempting to latch
- Colic symptoms
- Reflux symptoms
- Poor weight gain
- Continuous feedings
- Gumming or chewing of the nipple
- Unable to take a pacifier or bottle
- Creased, cracked, bruised or blistered nipples
- Bleeding nipples
- Incomplete breast drainage
- Infected nipples or breasts
- Plugged ducts
- Mastitis (inflammation of the breast)
- Nipple thrush

PROCEDURE Addressing frenums is simple in children less than 9 months old. Older children can require the use of general anesthesia or conscious sedation that would be referred to the oral surgeon or require an anesthesiologist to be brought in. The procedure itself takes less than a minute each frenum. Dr. Cole uses a laser that cuts and seals the tissues resulting in very little or no bleeding. The laser procedure takes slightly longer than a clipping procedure but is the preferred method of Dr. Cole due to the minimal bleeding and lower probability of healing back together. We start by using a specially compounded topical anesthetic on the upper lip frenum but not the tongue since there is minimal nerve development in that area and we want the baby to be able to nurse immediately after the procedure. After the topical is placed, the baby is swaddled and placed in our dental chair while being stabilized by an adult to minimize movement during the procedure. Then the laser procedure is completed and aloe vera gel placed on the site. The baby and mom are left in the room to nurse. Babies will cry during the procedure, not because they are in pain, but because they are being wrapped up and something is in their mouth that is not food.

ALTERNATIVE TREATMENTS The alternative to laser treatment includes scalpel surgery using local anesthesia and/or sedation. The other alternative is to do no treatment. No treatment could result in some or all of the conditions listed under "Symptoms" above. Advantages (benefits) of laser vs. scalpel or scissors include lower probability of re-healing, less bleeding, no sutures (stitches) or having to remove sutures. Disadvantages (risks) are included in the "Risks of Procedure" below.

POST OP INSTRUCTIONS Following the procedure the baby may be fussy and may not nurse much at first. Breastfeeding will have to be retrained so may be difficult at first. Some swelling and/or a fever may occur during the first 24 hours but then should go down. Children's Tylenol can be administered to help with this. Some aloe vera gel will be dispensed, and should be placed on the wound area 2-4 times a day. Keeping the lip and tongue mobile is important during the healing time. When nursing make sure to flange the upper lip up and over the breast to stretch the area and lift the tongue with a tongue blade or your fingers to keep the tongue mobile. Doing this at least two times a day is sufficient. A way to help retrain the nursing can be to use a bottle nipple, which is more rigid than the breast. Pushing the bottle deeper in the baby's mouth and flanging the lips over will force the tongue forward and create a proper sucking habit. A white patch around the lasered area is normal and this is the clotting material in the mouth. Keep the area stretched and mobile until all the white is replaced by pink tissue.

RISKS OF PROCEDURE While the majority of patients have an uneventful surgery/procedure and recovery, a few cases may be associated with complications. There are some risks/complications, which can include:

- Bleeding. This may occur either at the time of the procedure or in the first 2 weeks after.
- Infection.
- Pain.
- Damage to sublingual gland, which sits below the tongue. This may require further surgery.
- Injury to the teeth, lip, gums, or tongue.
- Burns from the equipment.
- The frenum can heal back and require further surgery.
- Swelling and inflammation, especially of upper lip.
- Scarring is rare but possible.
- Eye damage if baby or parent looks directly into the laser beam. Complete eye protection is available for all.

PARENT CONSENT I acknowledge that the doctor has explained my child's condition and the proposed procedure. I understand the risks of the procedure, including the risks that are specific to my child and the likely outcomes. I was able to ask questions and raise concerns with the doctor about my child's condition, the procedure and its risks, and treatment options. My questions and concerns have been discussed and answered to my satisfaction. I understand that photographs or video footage may be taken during my child's procedure and these may be used for teaching health professionals. (Your child will not be identified in any photo or video). I understand that no guarantee has been made that the procedure will improve the condition and that the procedure may make my child's condition worse. On the basis of the above statements, I REQUEST THAT MY CHILD HAS THE PROCEDURE.

Name of Patient: _____ Date: _____

Signature of Parent/Substitute decision maker: _____

Witness: _____ Doctor: _____

Informed Consent:

I _____ (mother, father, guardian) of _____ d.o.b. _____ have been informed of the laser frenectomy procedure(s) to be administered to my son/daughter. The benefits and possible risks of treatment as well as alternative care options were discussed and I was provided ample opportunity to have all of my questions and concerns addressed. The option of *no treatment* was also presented and it is understood that this option was not elected as the potential benefit for treatment vs. no treatment is understood. Dr. Martin A. Kaplan D.M.D. will be performing a laser frenectomy to release the physical restriction of the frenulum. The intent is to remove the frenulum which through reported symptoms, physical exam and written history provides reason for treatment. The expectation is that by removing the frenulum there will be the establishment of a more normal lip and/or tongue posture and movement. The presence of the frenulum in this case is most likely one of the causes for the latching problems during breastfeeding. It is understood that though the intent is to alleviate the problem by frenectomy, there is no inherent guarantee that this will result in a cure of the problem. However, it is understood that the frenulum in my case is a contributing cause to my current nursing difficulty.

I further understand that I am responsible to provide the post-op physiotherapy (stretching of the treated area/s) as directed. This will help assure the best possible result. I am to return to my IBCLC (Lactation consultant) for follow-up guidance for nursing my baby.

Post-op complications may be discomfort, irritability, fatigue, temporary refusal to nurse and possible swelling and fever. It is unlikely that there will be any infection.

Signed: _____

Relationship _____ date: _____

INFORMED CONSENT FORM FOR INFANT ORAL SURGERY

Prior to completing any oral care on your infant, we require your consent to treat your child. It is the philosophy of this office to provide children with the highest quality of care in a manner which is as pleasant and as safe as possible. During treatment on small infants, it may be necessary for your infant to be swaddled or placed in a similar protective appliance to control undesirable movements. In some instances, there may be a need for the Doctor to numb the surgical area using a small amount of local anesthetic and to provide adequate visibility and access to the surgical areas using a comfortable mouth prop. Older infants may require some type of oral premedication, which if needed, will be discussed prior to having any child sedated. The purpose of all these procedures are to gain and maintain good oral health, primarily at this age, breastfeeding, reducing maternal discomfort and in many instances, future problems that may be associated with lingual and or lip-ties. The Doctor anticipates good results, however, no guarantees as to the results are given. Laser treatment usually proceeds as planned; however, as in all areas of medicine, results cannot be guaranteed, nor can all consequences be anticipated. Post-surgical discomfort may be minimal or last as long as a week before our goals are met. Bleeding is always a rare possibility; however, after completing this type of surgery, this office has not experienced any significant problems that would indicate any serious risks of the surgery. Not treating existing dental problems in children may result in breastfeeding problems. Successful breastfeeding is our primary goal for today's surgery. Parents and guardians should understand recommended procedures, alternative options and anticipated results. All surgery in this office is completed using appropriate laser technology, which has proven safe for infants as well as all patients. Successful results of this surgery are dependent on parents following carefully all post-operative recommendations for keeping the surgical sites from healing together, seeing their lactation consultant and if indicated a cranial-sacral therapist.

ACKNOWLEDGMENT OF INFORMED CONSENT

I hereby acknowledge that I have been fully informed as to the treatment considerations. I have read and understand this form. I understand the advantages and disadvantages of treatment as well as alternative means of completing these procedures. I understand that my infant will be treated while I remain in the consultation room. The Office has explained to you, the purpose of the surgery through a consultation involving photos and oral discussions and written information. I have been given the opportunity to ask the Doctor all questions I have about the proposed surgical treatment. All questions and concerns have been discussed. I give my free and voluntary, informed consent for treatment to be completed. By signing this consent form, I indicate that I have legal authority to grant this permission. I also agree to pay all fees and have given the Doctor a complete medical history of my child.

(Print Child's Name)

(Parent's/Guardian's Signature)

(Today's Date)

Witness Signature _____

NOTE: During office procedures, photographs or video of interesting cases may be completed. We would like your consent to use these for educational purposes such as lectures or professional articles to advance breastfeeding.

CONSENT TO USE PHOTOS AND VIDEOS _____
(Parent's/Guardian's Signature)

Frenectomy: *Informed Consent Form*

Diagnosis: After a thorough oral examination, my child’s dentist has advised me that the reduction of a frenum(s) in my child’s mouth may help to restore anatomy, function, and/or possibly prevent commonly associated future problems.

Recommended Treatment: In order to treat this condition, my child’s dentist has recommended that a frenectomy be performed at the selected site(s). A soft tissue laser will be utilized. This very laser is FDA approved for this soft tissue surgery and is an excellent tool to optimize treatment and recovery.

Principle Complications: I understand that a smooth recovery is expected, however, there are always associated risks that cannot be eliminated and may occur in a minority of cases. These complications include but are not limited to post-surgical bleeding, infection, swelling, pain, damage to adjacent structures such as salivary glands, nerve, muscle, and skin. A more common complication is re-attachment of the frenum. Genetics also plays a strong role in healing, such as formation of scar, keloid, or overt fibrous tissue formation.

Follow Up: I am advised to return for a 1-week check, and a 3 week check to follow up on the proposed care. Photos may be taken, but not of the face without permission.

Alternatives to Suggested Treatment: I understand that alternatives to a frenectomy include: no frenectomy, with the expectation that the frenum does not normally improve with age but may aggravate the surrounding tissues including the gums and teeth. Also, an alterative to a frenectomy by my dentist is to seek the care of another health care professional, including but not limited to doctors of general dentistry, periodontics, oral surgery, ENT, and plastic surgery. The use of the laser itself can be deferred to more traditional instruments of care.

No Warranty or Guarantee:

I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. I do expect however that the doctor perform the surgery to the best of his ability.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT
AND ALL MY QUESTIONS WERE ANSWERED

Date

(signature of parent, guardian, or patient)

Date

(signature of witness)