

**CONTRIBUTED BY**

**Martin A. Kaplan DMD**

**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_