PNW Tongue tie
Child Frenectomy Informed Consent:

I_____ (mother, father, guardian) of _____ d.o.b. _____have been informed of the laser frenectomy procedure(s) to be performed on my son/daughter. The benefits and possible risks of treatment as well as alternative care options, including no treatment, were discussed and I was provided ample opportunity to have all of my questions and concerns addressed.

Shadi Araghi, DDS 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 speech issues It is understood that though the intent is to alleviate the problem by frenectomy, there is no guarantee that this will cure the problem. I understand that the frenulum is likely a contributing cause to speech, feeding, sleep, or other difficulties. I further understand that I am responsible to provide the post-op stretching exercises as directed. This will help assure the best possible result. I am to return to my therapist for follow-up guidance for my child.

Post-op complications may be discomfort, minor bleeding, reattachment, and less commonly fever and infection.

Signed:_____
Relationship_____date:_____

Doctor signature: _____ date: _____

Witness signature: _____ date: _____