Advanced Oral Cancer Screening Consent Form

Patient's Name: ____ Date of Birth: ____________________

Last First Initial

Office Name: ____ Dentist Name: ____________________________

Please initial each box to denote understanding

☐ To provide optimum screening and oral health care, in addition to the visual and palpable tissue exam that will be provide at each dental exam, advanced oral tissue screening technology is offered for all adult and high risk patients annually as a standard of care. This life-saving standard is proven for early detection of cancers similar to the early detection provided by mammography, Pap smear, and PSA.

☐ I understand that while the visual and palpable exam reveals dangerous lesions that are in the later stages, suspicious tissues are most treatable, with lowest risk of mortality, in the earliest stages. Advanced screening (florescence) technology is used to effectively examine tissues for abnormalities in the earliest stages that are not visible to the unaided eye. This additional step in the tissue exam is not a diagnostic tool, however, it is effective as an enhanced screening tool.

☐ Consenting to this annual advanced oral cancer screening will allow my dental providers to perform the most thorough and enhanced screening to decipher between healthy tissues and suspicious lesions. Refusing the use of this advanced technology will not allow my provider to inform me of lesions unseen without this technology. Early detection is my best opportunity to seek treatment when recovery is minimal and risk of mortality is lowest.

☐ I have had the opportunity to discuss the benefits of this advanced screening and ask any questions.

Risks

☐ Risks include additional testing, as use of this technology could lead to need for a biopsy if tissues appear abnormal.

Alternatives

☐ Alternative evaluations could include testing with Toluidine Blue as an adjunctive for recognizing and identifying the extent early of abnormal tissues.

Authorizations

☐ I authorize my dental provider to perform the advanced oral cancer screening along with the visual and palpable exam as a standard of care.

☐ I decline to authorize this advanced oral cancer screening and understand that refusing the use of this advanced technology will not allow my provider to inform me of lesions unseen without this technology. I am also aware that, as a standard of care, I will be offered the opportunity to receive this screening annually.

Signed:_______________________________________ Date:_______________________________________

Patient or Guardian

Signed:_______________________________________ Date:_______________________________________

Treating Dentist

Signed:_______________________________________ Date:_______________________________________

Witness