ORAL &MAXILLOFACIAL SURGERY

CONSENT FOR TREATMENT FOR REPAIR OF FACIALBONE FRACTURES

Patient's Name Age/Sex Date

Please initial on each page after reading. If you have any questions, please ask your doctor BEFORE initialing.

My doctor has explained to me that there are inherent and potential risk and side effects associated with my proposed treatment and in this specific instance, but they are not limited to

1. Damage to or loss of teeth in the area of trauma or fracture, loss of vitality of those teeth with requirement for future root canal therapy, loss of dental restoration, accidental swallowing or aspiration of tooth or foreign object, devitalization of bone and soft tissue in the area of trauma which may result in some loss of tissue.
2. Unusual procedures required during surgery such as incomplete removal of tooth, which endanger adjacent vital structures.
3. Post operative swelling, discomfort, bruising, bleeding, hematoma (blood clot), wound infection or dehiscence, sinusitis and limitations of function, any of which require further care.
4. Adverse or allergic reactions to medications or anesthesia causing multiple side effects, some of which may be serious and require additional care or hospitalization.
5. Reaction to foreign material which may have been introduced into the wound by the trauma, or "tattooing" of the skin or mucosa from particles of foreign material
6. Change in occlusion (bite) and jaw function after treatment; secondary problems of the jaw joint (TMJ) which may be prolonged, or even permanent, and which may require future treatment.
7. Possibility of otologic (ear related) complications such as perforation, infections, decrease in function of parotid gland(one of the gland responsible for saliva secretion),formation of fistula over preauricular& retromandibular region(areas of lateral

surface of face), mandibular hypomobility in long term experience, ankylosis of TMJ during surgeries of TMJ joint.

8. Scarring either inside or outside of the mouth, depending on the nature and force of the trauma and the locations of certain incisions required in treatment.
9. Facial muscle weakness particularly of the lip, eyelid or other muscles of expression caused by injury to motor nerves in the area of the trauma. Such weakness may be partial or total and may be temporary or permanent.

Signature -----------------

10. Sensory nerve injury causing pain, numbness, or other sensory alterations anywhere in the mouth, tongue, cheek, lip, and areas of facial skin which may be temporary or permanent.
11. Wiring the teeth together during the time required for healing of bone fractures will significantly reduce oral hygiene effectiveness, which may then lead to or worsen periodontal (gum) disease, bleeding gums, discomfort and loosening of teeth. Following treatment for facial injury, any such conditions must be treated. Jaw wiring will decrease normal diet and cause temporary weight loss.
12. Certain wires, screws, plates, splints or other fixation devices may be introduced, and some may require later removal.
13. Unusual effects related to hardware used such as metal sensitivity, Infection ,screw fracture, plate fracture or plate exposure.
14. Non-union or malunion of bony fractures, possibly requiring re-treatment. Some cosmetic or functional deformity may occur in areas adjacent to the trauma or repair

I understand that additional injury may be discovered during treatment that might necessitate a change in approach or a different procedure from those explained above and I authorize my doctor to perform such procedures that are necessary and advisable in the exercise of professional judgment.

I understand that this is complex treatment and there can be no guarantee of complete resolution of my present symptoms or jaw/teeth/facial bone injury. Occasionally there may be increased symptoms post-operatively (for example, numbness). I also understand that additional treatment may be necessary post-operatively, including (but not restricted to) physical therapy, reconstructive dentistry, orthodontics, retreatment of bone fractures including bone grafting, removal of certain fixation devices, or TMJ treatment. I agree to cooperate with my doctor's recommendations during treatment, realizing that lack of cooperation will result in a less-than-optimal result.

I have discussed my past medical history with my doctor and have disclosed all diseases and medications, including alcohol and drug use (past and present).

Signature ------------------------

I have had an opportunity to have all my questions answered by my doctor that all blanks on this form were filled in prior to my signing, and I certify that I understand English. My signature below signifies that I understand the surgery and anesthetic that is proposed for me, together with the known risks and complications associated. I hereby give my consent for such surgery and anesthesia I have chosen.

Patients(or guardian`s) signature &Date

Witness signature:

1.

2.

Doctor`s signature