AOMSI CONSENT FORM

For A Safer Tomorrow

ORAL AND MAXILLOFACIAL SURGERY

CONSENT FOR TREATMENT FOR REPAIR OF TEMPORO-MANDIBULAR JOINT

Patient's Name Age/Sex Date

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

Dr. _____ has explained to me about the pathology (disease) that exists in my right and/or left temporomandibular joints (lower jaw joint).

I understand that my condition of limited or compromised function and/or pain may be secondary to a number of possible processes including, but not limited to

1.Traumatic injury

2. Malocclusion

3. Articular displacement (cartilage dislocation)

4. Degenerative joint disease, inflammation

5. Infection

6. Arthritis

7. Vascular injuries(hematoma formation)

8. Instrument breakage during arthroscopy

9. Ankylosis(fibrous union / bony union of joint)

Signature ----------

9. Chronic pain

10. Material failure (foreign body reaction)

11. Frey`s syndrome (sweating over temporal region on operated side)

12. Neruosensory disturbances (numbness over skin and adjacent area of operated site)

13. Otology complications (ear related)

14. Intracranial injuries (Dural tear, cerebrospinal fluid leak)

15. Post operative maxilla-mandibular fixation

16. Objectionable scar formation.

17. Facial swelling lasting for longer period of time

I understand that the surgery to be performed is an exploratory procedure and the treatment rendered at that time will be based on the findings during surgery.

Surgical treatment may includes **mark the procedure**

1. Meniscus repair ☐

2. Meniscectomy (removal of cartilage) ☐

3. Placement of an implant ☐

4. Eminectomy ☐

5. Condylectomy. ☐

6. Arthroscopy ☐

7. Arthrocentisis ☐

8. Gap arthroplasty(release of ankylotic mass) ☐

9.Ligament Plication ☐

10.Interpositional Arthroplasty ☐

11.TMJReconstruction ☐

I (we) understand that my surgeon may discover other or different conditions which require additional or different procedures than those planned.

I (we) understand that no warranty or guarantee has been made to me as to a result or cure. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:

1. Facial nerve paralysis with inability to close eyelid on the affected side.

2. Inability to wrinkle the forehead.

3. Inability to blow air from mouth

4. burning sensation of eye due to inability to close eyelids

5. drooling of saliva from corner of mouth

6. Infection.

7. Resultant malocclusion (incorrect bite) and limited opening of jaw.

8. Lack of improvement or worsening of pain and jaw dysfunction.

9. Further degenerative changes with the temporomandibular joint (TMJ).

Patients (or guardian`s) signature & Date

Witness signature:

1.

2.

Doctor`s signature