

CONSENT FOR FACIAL RECONSTRUCTION SURGERY

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Patient's Name

Date

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

- ____ 1. I authorize **Dr. Tyler L. Clark** and his authorized associates and staff to treat my condition diagnosed as: _____

- ____ 2. The procedure(s) necessary to treat the condition(s) noted above has/have been explained to me, and I understand it/them to be: _____

- ____ 3. Other options and alternatives to this procedure include no treatment at all, or: _____

- I understand those options and the benefits and risks of each.
- ____ 4. The proposed treatment has been outlined for me in laymen's terms and possible complications and side effects have been discussed, including (but not limited to):
- ____ A. Post-operative swelling, discomfort, bruising, bleeding, hematoma (blood clot), wound infection, and limitation of function, any of which may require further care. Wound infection that does not respond well to normal antibiotic therapy may result in loss of the grafted bone.
 - ____ B. Adverse or allergic reactions to medications or anesthesia causing multiple side effects, some of which may be serious and require additional care or hospitalization.
 - ____ C. Change in jaw function after treatment; or secondary problems of the jaw joint (TMJ) which may be prolonged, or even permanent, and which may require future treatment. Pre-existing TMJ disorders are more likely to worsen after surgery.
 - ____ D. Scarring either inside or outside the mouth, depending on the nature and locations of certain incisions required in treatment.
 - ____ E. Facial muscle weakness, particularly of the lips, chin, tongue (including possible loss of taste sensation), eyelids 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.
 - ____ F. Sensory nerve injury causing pain, numbness, or other sensory alterations anywhere in the mouth, tongue, cheeks, lips, floor of mouth, throat and areas of facial skin. Such symptoms may be temporary or permanent.

- _____ G. Wiring the jaws together during the time required for bone healing 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, any such conditions must be treated. Jaw wiring will decrease normal diet and cause temporary weight loss.
 - _____ H. Certain wires, screws, plates, splints or other fixation devices may be introduced, and some may require later removal.
 - _____ I. Resorption (loss; partial or complete), non-union or malunion of bone, possibly requiring re-treatment. Some cosmetic or functional deformity may occur in areas adjacent to the repair.
- _____ 5. I understand that additional conditions 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 judgement.
- _____ 6. I understand that this is complex treatment and there can be no guarantee of complete resolution of my present condition. I am aware of some expected change in my appearance, and I understand some cosmetic changes may result that cannot be exactly predicted. Bone grafts resorb to some degree, but the exact amount is not known in each individual patient. 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, re-treatment including additional 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 understand that recuperation may take a considerable time and that the full effect of my treatment may not be evident for a year or more.
- _____ 7. I realize the importance of providing true and accurate information about my health. I have discussed my past medical history with my doctor and have disclosed all allergies, diseases and medications, including alcohol and drug use (past and present).
- _____ 8. I have been told of my option for a second opinion regarding the proposed treatment from another qualified professional.
- _____ 9. I have been advised of the opportunity for blood donation before surgery so that my own blood may be given back to me (auto-transfusion) if necessary.

Surgical time out _____

CONSENT

By signing this consent form, I acknowledge that I have read it completely and understand the procedure to be performed, the risks and the alternatives to surgery. I have had all my questions answered to my satisfaction. I was under no pressure to sign this form and have made a voluntary choice to proceed with the proposed treatment. I am fully aware that no guarantee or warranty can be made regarding the results of treatment. I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date

Print Witness' Name and Address

Unless sooner terminated in writing, this consent shall remain in force for 60 days from the date it is signed by the Patient. A facsimile transmission, and/or an electronic scanned transmission, shall constitute an original.