

CONSENT FOR CORTICAL BONE GRAFTING

PAGE 1 OF 3

Patient's Name

Date

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

You have the right to be informed about your condition and the recommended treatment plan. This disclosure is meant to provide information to help you understand the possible risks and complications of treatment, so you may decide to give or withhold your consent.

_____ 1. My condition has been explained to me as:

_____ 2. The procedure necessary to treat the condition has been explained to me as *CORTICAL BONE GRAFTING*. This involves taking a segment of bone from the front of the chin area and transferring it to the site(s) where bone support has been determined to be deficient (usually for placing a dental implant). In situations where larger quantities of bone are required, the donor site may also include an outer portion of the jaw further toward the back on either or both sides.

_____ 3. I have been informed of possible alternate methods of treatment (if any) including:

I understand that these other forms of treatment, or no treatment at all are choices I have and the risks of those choices have been presented to me.

_____ 4. My doctor has explained to me that there are certain risks and side effects associated with my proposed treatment and, in this specific instance, they include, but are not limited to:

_____ A. Post-operative discomfort and swelling requiring several days of at-home recovery.

_____ B. Prolonged or heavy bleeding that may require additional treatment.

_____ C. Injury or damage to the blood supply of teeth adjacent to the graft donor site. That may require root canal treatment of affected tooth, or even result in their eventual loss.

_____ D. Post-operative infection that may adversely affect the new bone graft and require additional treatment.

_____ E. Scarring at the site of incisions inside the mouth, which also may have cosmetic effects on the skin.

_____ F. Osteomyelitis, a chronic bone infection at either donor or recipient graft site, which may require long-term antibiotic therapy or other treatment.

_____ G. Unexpected exposure of the screws or wires used to fix the bone graft requiring their loss or premature removal, and possible loss of the bone graft.

_____ H. Fracture of the jaw.

_____ I. Injury to sensory nerves in either donor or recipient sites, resulting in numbness, tingling, pain, or other sensory disturbances in the chin, lip, cheek, face, teeth, gums or tongue, and which may persist for several weeks or months, or rarely may be permanent.

_____ J. Failure of the graft to integrate with natural bone, loss of vitality or other unexpected loss of the bone graft.

_____ K. To supplement the cortical graft, natural particles of donor bone, or other forms of synthetic bone are often packed around the cortical graft. These particles may also become devitalized and be lost, often over some period of time.

_____ L. Biologic/synthetic membranes are often used to contain and protect the graft. Some may require a second procedure to remove them; or some may be unexpectedly lost in which case the graft may be adversely affected.

_____ M. This grafting procedure is planned in two stages: one to take and place the graft, then a second to remove various fixation devices (screws, wires, membranes). If planned, dental implants may be placed at the second stage, or weeks or months of further healing may be required before the bone graft is sufficiently mature to place implants.

_____ N. Allergic reactions (previously unknown) to any medications used in treatment.

_____ 5. I understand that I must commit to timely placement of the planned dental implant. If too much time passes, the bone graft may resorb (“melt away”) and the resulting deficient bone will not permit implant placement.

_____ 6. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

_____ 7. The anesthetic I have chosen for my surgery is:

_____ Local Anesthesia

_____ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia

_____ Local Anesthesia with Oral Premedication

_____ Local Anesthesia with Intravenous Sedation

_____ 8. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation (phlebitis) at the site of an intravenous injection that may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and although considered safe, does carry the rare risks of heart irregularities, heart attack, stroke, brain damage or even death.

_____ 9. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED:**

- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
- B. During recovery time you should not drive, operate complicated machinery or devices, or make important business decisions.
- C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
- D. **However**, it is important to take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by us, **using only a small sip of water.**

_____ 10. It has been explained to me, and I understand that perfect results cannot be guaranteed.

Surgical time out _____

CONSENT

I certify that I speak, read and write English, that I fully understand this consent form for surgery, and that all blanks were filled in prior to my initialing and signing this form. All my questions have been answered to my satisfaction and I am willing to undergo the proposed surgery.

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.

09/2009