AOMSI CONSENT FORM

For A Safer Tomorrow

CONSENT FOR MINOR ORAL &MAXILLOFACIAL SURGERY

PATIENT 'S NAME : ……
DATE : ……
PLACE : ……
DIAGNOSIS : ……
TREATMENT PLAN : ……

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

1. Post-operative swelling and discomfort that may require several days of recovery.
2. Prolonged or heavy bleeding that may require additional treatment.
3. Injury or loosening of adjacent teeth or fillings.
4. Post-operative infection that may require additional treatment.
5. Stretching of the corners of the mouth that may cause cracking or bruising and may heal slowly.
6. Restricted mouth opening during healing sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints(TMJ),especially when TMJ problem already exists.
7. A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk of other complications.
8. Fracture of the jaw (usefully only in more complicated extraction or surgery)
9. Injury to the nerve adjacent to teeth, resulting in pain numbness tingling or sensory disturbances on the chin, lip, cheek, gums or tongue and which may persist for several weeks, months, or in rare instances permanently.
10. It has been explained that during the course of treatment unforeseen conditions may result that may require change in the procedure, I authorize my Doctor to use professional judgement to perform such additional procedures that are necessary to complete my surgery.

The Anaesthetic I have chosen for my surgery is

- Local anaesthesia
- Local with oral premedication
- Local with intravenous sedation
- General anaesthesia

It has been explained to me and I fully understand that a perfect result is not or cannot be guaranteed.

I have read and fully understood the above and discussed this operation and alternative treatment with _____. He has given me ample opportunity to ask questions about specific points and has answered those questions to my satisfaction.

PLEASE ASK YOUR DOCTOR IF U HAVE QUESTIONS CONCERNING THIS CONSENT FORM

PATIENTS (OR LEGAL GUARDIANS) SIGNATURE DATE

SURGEON's NAME:

AOMSI CONSENT FORM

For A Safer Tomorrow

CONSENT FOR TREATMENT FOR REPAIR FACIAL TRAUMA/DENTO ALVEOLAR INJURY

PATIENT 'S NAME : …….
DATE : …….
PLACE : …….
DIAGNOSIS : …….
TREATMENT PLAN : …….

- 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:

A. 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, devitalisation of bone and soft tissue in the area of trauma which may result in some loss of tissue.

B. Post-operative swelling, discomfort, bruising, bleeding, hematoma (blood clot), wound infection, sinusitis and limitations of function, any of which may require further care

C. Adverse or allergic reactions to medications or anaesthesia causing multiple side effects, some of which may be serious and require additional care or hospitalization

D. Reaction to foreign material which may have been introduced into the wound by the trauma or "tattooing" of the skin or mucosa from particles or foreign materials

E. 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

F. Scarring either inside or outside the mouth, depending on the nature and force of the trauma and the locations of certain incisions requiring treatment

G. Facial muscle weakness, particularly of the lip, eyelid or other muscles of expression caused by injury to motor nerves in the area of trauma. Such weakness may be partial or total and maybe temporary or permanent

H. Sensory nerve injury causing pain, numbness, or other sensory alterations in the mouth, tongue, cheek, lip and areas of facial skin which may be temporary or permanent

I. Wiring the teeth together during the time required for healing of bone fractures will significantly affect oral hygiene effectiveness which may then lead to or worsen periodontal (gum) disease, bleeding gums, discomfort and loosening of teeth. Following treatment or facial injury, any such conditions must be treated. Jaw wiring will decrease normal diet and cause temporary weight loss

J. Certain wires, screws, plates, splints or other fixation devices may be introduced and some may require removal, later.

K. Non-union or malunion of bony fractures, possibly requiring retreatment. 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 judgement

I understand that this is complex treatment and 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 eg numbness) I also understand that additional treatment may be necessary postoperatively, 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 doctors recommendations during treatment, realising 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).

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.

In cases wherein patient can't understand English a translator was used to explain the patient in his mother tongue language.

Patient's (or Guardians) SignatureDate

Signature of Translator:

Surgeons Name:

Hospital Name:

ORAL AND MAXILLOFACIAL
SURGEON_____

AOMSI CONSENT FORM

For A Safer Tomorrow

Consent For Two Stage Osseointegrated Implant Surgery

Patient's Name_____
Date _____

1. I hereby authorize Dr_____ (Surgeon) and Dr _____(Prosthodontist) and his assistant to treat the condition described as:

   _____

   _____

2. The procedure offered to treat the condition has been explained to me and I understand the nature of the procedure to be:

   _____

   _____

3. I understand that incision will be made in my mouth for the purpose of placing one or more endosteal root from structures (implant) in my jaw to serve as anchors for a missing tooth or replacement or to stabilize a crown (cap), bridge or denture. I acknowledge that the doctor has explained the procedure, including the number and location of the incisions and the type of implant to be used. I understand that the crown, bridge or denture that will later be attached to this implant will be made and attached by Dr …….

4. I understand that the implant must remain covered by gum tissue for at or more three months before being used and that a 2nd surgical procedure is required to uncover the top of the implant. No guarantee can be or has been given that the implant(s) will last for a specific time period. It has been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If the planned schedule is not carried out, it will be one of causes of implant failure.

5. I have been informed of possible alternative method of treatment (if any), including

_____

_____

My doctor has explained to me that there are certain inherent and potential risks and side effects of any surgical procedure and in this specific instance such risks include, but are not limited to:

A. Post-operative discomfort and swelling that may require several days of at home recuperation
B. Prolonged or heavy bleeding that may require additional treatment
C. Injury or damage to adjacent teeth or roots of adjacent teeth
D. Post-operative infection that may require additional treatment
E. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly
F. Restricted mouth opening for several days, sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ)
G. Injury to nerve branches in the lower jaw resulting in pain, numbness or tingling of the chin, lips, cheek, gums or tongue on the operated side(s) these symptoms may persist for several weeks, months or in rare instances, may be permanent
H. Opening into the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment. If the sinus is intentionally entered (sinus lift procedure with grafting), there may be several weeks of sinusitis symptoms requiring certain medications and additional recovery time
I. Fracture of the jaw or perforation of thin bony plates
J. Use of other materials which may have to be removed at a later date
K. Bone loss around implants
L. Implant or prosthesis fracture, or loss of implant due to rejection by body
M. Other:

6. It has been explained to me that during the course of surgery unforeseen conditions may be revealed which necessitate extension of the original procedure or a different procedure from that set forth in paragraph 2

above. I authorize my doctor and his staff to perform such additional procedures as are necessary and desirable in the exercise of professional judgement

7. I consent to the administration of anaesthesia I have chosen for my surgery is
    - ☐ Local anaesthesia
    - ☐ Local with intravenous sedation / General anaesthesia

CONSENT:

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English. I understand that no guarantee can be promised and I give my free and voluntary consent for treatment.

BEFORE SIGNING, PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THE INFORMATION ON THIS CONSENT FORMS

Patient's (Guardian's) Signature Date

Witness' Signature Date

Doctor's Signature
Date