FACIAL RECONSTRUCTION AND FRACTURE REPAIR INFORMED CONSENT

_____ _____

Patient's Name Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: _____

Procedure: _____

Alternative options: _____

_____

1. I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:
    - Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials;
    - Nerve injury, which may occur from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;
    - Loss of function and/or weakness of facial expression muscles possibly affecting my appearance. Such conditions may resolve over time, but in some cases may be permanent;
    - Altered or loss of sensation to the palate or throat resulting in a change in the sound of my voice and/or difficulty with speech, fluid reflux, swallowing or eating certain foods. Such injuries may resolve over time, but in some cases may be permanent;
    - Facial deformity; Abnormal, enlarged, or cosmetically unpleasing scars may occur within the skin and deeper tissue, sometimes requiring additional surgery. Some scarring may be permanent and always be visible;
    - Inability to fully reposition tooth requiring orthodontic movement to place tooth in proper position and/or stabilize the tooth; Changes in bite that may resolve over time and/or require prolonged orthodontic treatment to attempt correction, but in some cases may be permanent;

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- Failure of the bones to heal; Repositioned bony segments may return to their original position (relapse);
- Diminished sense of smell if the upper jaw or mid-facial area is operated on;
- Discharge from the nose. If nasal packing is used, breathing may be difficult in the short term and there might be an unpleasant odor;
- An opening may occur from the mouth into the nasal or sinus cavities;
- Muscle spasm in the jaw joints; Pre-existing jaw joint disorders may worsen;
- Visual complications including dry eyes, changes in tear flow, turning outward of the lower eyelid, corneal abrasion, swelling, infection of the eye socket, and/or, in rare instances, blindness;
- Blood clot or fluid accumulation; Severe bleeding, both during and after surgery, that may require a blood transfusion; Bleeding in the brain;
- The formation of a blood clot within a cavity at the base of the brain, brain abscess, and/or development of meningitis;
- Hardware (e.g., screws, plates, pins, wires, etc.) may be needed in order to best repair the injuries. Some hardware may need to be placed on the outside of the face. The final decisions as to what to use will be made by the surgeon at the time of the surgery. You may be able to see and/or feel hardware that has been placed. It may be necessary to remove hardware at separate surgeries later.
- If cranial fixation devices are used, risks related to this surgical procedure include but are not limited to brain injury, infection from the fixation pins placed in the skull, discomfort, disruption of normal activities, scarring, hair loss, and/or numbness in the area of the external pins;
- If wires are used, risks related to this surgical procedure include but are not limited to worsening gum disease, bleeding gums, discomfort, loosening of teeth, airway obstruction, and/or temporary weight loss.

2. I have elected to proceed with the anesthesia(s) indicated below.

_____ Local Anesthesia

_____ Nitrous Oxide (Laughing Gas)

_____ Mild Sedation

_____ Moderate Sedation

_____ Deep Sedation (General Anesthesia)

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I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

- Allergic or adverse reactions to medications or materials;
- Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed. Usually the numbness or pain goes away, but in some cases, it may be permanent;
- Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have an awareness of some or all events of the surgical procedure after it is over;
- Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death;
- Sore throat or hoarseness if a breathing tube is used.

If I have elected Mild, Moderate, or Deep Sedation (General Anesthesia), I have not had anything to eat or drink for at least six (6) hours prior to my procedure. I understand that doing otherwise may be life-threatening. As instructed, I have taken my regular medications (blood pressure medications, antibiotics, etc.) and/or any medicine given to me by my doctor using only small sips of water. I am accompanied by a responsible adult to drive me to and from the doctor's office and he/she will stay with me after the procedure until I am recovered sufficiently to care for myself. I understand the drugs given to me for this procedure may not wear off for 24 hours. During my recovery from anesthesia, I agree not to drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

3. I have been informed of and understand that follow up visits or care, additional evaluation, treatment or surgery, and/or hospitalization may be needed.

4. I understand that the wounds, incisions and hardware need to be kept clean. I understand that there may be ongoing problems with function and appearance. Bone and soft tissue in the area of the injury may not heal properly or worsen. I agree to carry wire cutters with me at all times if my jaws are wired and to avoid other activities that may cause nausea or airway problems.

5. Patient's Responsibilities
   I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

   I understand the use of tobacco and alcohol is detrimental to the success of my treatment.

   I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

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I understand and accept that the doctor cannot guarantee the results of the procedure**.** I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

If I am sedated or under general anesthesia during the procedure, I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature (optional) Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

_____ _____

Doctor Signature Date