MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT: GENERAL DENTISTRY'S STANDARD OPERATING PROCEDURES	ISSUANCE DATE: 20110310
LOCAL FORM TITLE: INFORMED CONSENT FOR ORAL SURGERY	

INFORMED CONSENT FOR ORAL SURGERY

You have the right to be fully informed of your diagnosis, the treatment options, as well as potential risks and complications so that you can make an educated decision whether or not to undergo surgery. Many of the risks and complications explained below are unlikely though still possible. This explanation is not meant to alarm you, rather it is to help you completely understand your surgical procedure. You will receive the most expert care available with every precaution taken to avoid any of these problems.

1. SWELLING, BRUISING & PAIN: Depending on the degree of difficulty, a certain amount can normally be expected with any surgical procedure. There may also be some stretching of the lips.

2. INFECTION: Infections are best prevented with proper home care post-operatively. Treatment may involve antibiotics and/or additional surgery for drainage.

3. BLEEDING: Minor oozing is not uncommon after surgery and usually controlled with pressure from gauze packs. Significant bleeding is rare.

4. DRUG REACTIONS: Reactions may include itching, rash, nausea/vomiting, or very rarely severe allergic (anaphylactic) shock and/or death. It is extremely important to reveal any past allergies or sensitivities. Additionally, drugs given for sedation can cause vein irritation, prolonged drowsiness, incoordination, low blood pressure or decreased breathing rate.

5. LIMITED JAW OPENING: Full opening of the jaw may be difficult for a few days following surgery due to local muscle swelling or spasm. In remote instances there is an injury to the jaw joint, (TMJ). Treatment of TMJ injuries may involve medication, rest, and rarely surgery.

6. NERVE DAMAGE: Nerves that give feeling to the lower lip, teeth, and gums, as well as to the tongue can occasionally lie close to tooth roots. If affected, numbness, tingling or burning can result. Normal feeling will usually return, but permanent injury to the nerve is rare.

7. SINUS COMMUNICATION: Upper back teeth may lie close or project into the sinus. Removal of these teeth may leave an opening from the mouth to the sinus, and/or result in sinus infection. Treatment may involve decongestants, antibiotics, and extra stitches. Rarely, additional surgery is necessary if the opening fails to heal.

8. DRY SOCKET: Pain due to loss of the blood clot from the extraction site. Symptoms can be quickly relieved by placing a medicated dressing against the bone. Smokers are at much greater risk and are strongly encouraged to stop at least during the healing period.

9. DAMAGE TO ADJACENT TEETH: Chipping of teeth or loosening of a filling or cap is possible if the tooth is weak or very close to the one being removed.

10. SHARP RIDGES/BONSE SPLINTERS: Occasionally a splinter of bone or the edge of the extraction socket will push through the gum tissue during healing. Treatment may involve removing the splinter or smoothing the bone.

11. RETAINED ROOT TIPS: Some teeth have severe curves or hooks at the end of roots. The decision may be made to leave in place a small piece of the tooth if attempting its removal would risk nerve damage or sinus opening. These areas normally heal uneventfully.

12. INJURY FROM INJECTION: In remote instances the injection of local anesthesia may cause swelling, bruising, infection, nerve damage, allergic or an unexpected (idiosyncratic) reaction.

13. JAW FRACTURE: Although quite rare, the risk for fracture increases with severely impacted teeth or associated cysts. Treatment can involve wiring the teeth together or a surgical procedure at the fracture area.

14. OTHER:_____

NAME: _____ PATIENT INITIALS: _____

This information is protected by the Privacy Act of 1974 (PL-93-579) and
the Health Insurance Portability and Accountability Act (PL 104-191)

PRACTITIONER'S/NURSE'S NAME	PRACTITIONER'S/NURSE'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION_____

1. OPERATION OR PROCEDURE_____

B. STATEMENT OF REQUEST_____

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

_____

(Description of operation or procedure in layman's language)

_____

Which is to be performed by or under the direction of Dr_____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation of procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the anesthesia staff of below-named medical facility, to be performed by, or under the direct supervision of a staff anesthesia provider.

4. Exceptions to surgery or anesthesia, if any, are: (If "none", so state)_____

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts, which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

7. I understand that as indicated, a Health Care Industry Representative may be present.

(Cross Out Any Parts Above That Are NOT appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s) as described above, expected results, attendant risks involved including, but not limited to:
A final assessment ("time out") was performed by all procedural team members BEFORE starting the procedure(s). This included (1) verification of patient identity (two identifiers), (2) correct side and/or site marked, (3) agreement on the procedure(s) being done, (4) correct patient position, (5) availability (if applicable) of special equipment and/or implants, (6) need for antibiotics and/or fluids for irrigation, (7) display of relevant images and/or results (if applicable), and (8) acknowledging need for any safety precautions based on patient history or medication use (e. g., allergies).

_____	_____	_____	_____
Signature of person performing "time out"	Date/time	Signature of Counseling Physician/Dentist	Date/time

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
Signature of Witness, excluding members of operating team	Signature of Patient	Date/Time

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
Signature of Witness, excluding members of operating team	Signature of Sponsor/Legal Guardian	Date/Time

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