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SURGERY

CONSENT FOR ARTHROCENTESIS OF THE TEMPOROMANDIBULAR JOINT

Patient's Name:_____ **Date**_____

PLEASE CHECK EACH BOX AFTER READING. If you have any questions please ask your doctor.

- ❑ I authorize Dr. Reynolds/Dr. Auble to perform the following procedure(s):Arthrocentesis of the Temporomandibular Joint(s) / Bilateral / Right / Left
- ❑ The arthroscopy procedure has been described to me and I understand that it is performed through a small skin incision or puncture just in front of my ear. A small telescope-like instrument is inserted through this incision directly into the jaw joint to inspect the inside of the joint. Occasionally a second skin incision is required for manipulating a second instrument or to facilitate joint washing (lavage). If possible, fibrous adhesions (scars within the joint) may be removed (lysis), which may be sufficient treatment to alleviate some of my joint symptoms.
- ❑ These procedures are necessary to treat the following condition(s): the pathology (disease) that exists in my jaw joint (TMJ, temporomandibular joint). I understand that this procedure is somewhat exploratory in nature and is being done to diagnose my jaw problem and may help to alleviate symptoms of pain and limitation of my jaw joint(s).
- ❑ The possible alternate methods of treatment (if any), include:_____
- ❑ I understand 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:
  - ❑ Temporary or permanent facial muscle weakness or paralysis resulting from injury to motor nerves in the area during surgery. The most common problem is an inability to wrinkle the brow, raise the eyebrow or gain tight closure of the eyelids.
  - ❑ Numbness (temporary or permanent) of certain areas of skin in the area of the joint and sometimes in more remote areas of the face or scalp.
  - ❑ During arthroscopy, bleeding may be encountered within or around the joint that cannot be adequately controlled through the scope instrument and may require immediate open surgery.
  - ❑ Due to the fact that arthroscopy is performed very close to the ear canal, ear problems may result, including inflammation of the canal, middle or inner ear infections, dizziness or loss of balance, and perforation of the ear drum with temporary or permanent hearing loss.
  - ❑ The possibility of instrument failure or separation that may require open surgery.
  - ❑ Facial scarring from skin incisions.
  - ❑ Possibility of damage to the jaw joint surface during arthroscopic examination and surgery. This is usually of a reversible nature but could permanently affect joint function.
  - ❑ Unsuccessful attempts to enter the joint or inability to accomplish the desired procedure because of limited joint mobility or other anatomic restriction.
  - ❑ Worsening of present TMJ symptoms that may require repeat arthroscopy or open joint surgery.
  - ❑ Changes in bite after arthroscopy that may affect chewing function. In addition there may be limited mouth opening. These are expected to be temporary, but may be permanent.
  - ❑ Postoperative infection requiring additional treatment.
  - ❑ Adverse or allergic reactions (previously unknown) to any of the medications used in the procedure.
  - ❑ Excessive swelling of the facial area that may take several days to resolve.
  - ❑ Complications associated with the use of medications and/or other pharmaceutical agents.
  - ❑ Other:_____

ADDITIONAL AGREEMENTS AND AUTHORIZATIONS

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- ❑ I further understand that a more involved procedure may still be required, depending upon the findings during this surgery. If such open joint surgery is required, I realize it may be done at the same time as this arthroscopy. If I desire an open joint surgery, I understand I will be asked to sign a separate consent form for that procedure.
- ❑ I understand that all of my current symptoms may not change after this procedure and that future additional treatments may require [physical therapy, splint therapy, restorative dentistry, orthodontics (braces), or further reconstruction of the temporomandibular joint, including implant devices or bone grafting.
- ❑ I agree to avoid the use of drugs, medicines and natural or homeopathic remedies not prescribed or approved by this office, and to avoid contact sports, water sports and strenuous physical activity for six weeks following arthroscopy.
- ❑ I agree to comply fully with physical therapy or other rehabilitative procedures prescribed by my surgeon.
- ❑ I have been given the opportunity to obtain a second opinion from a qualified professional regarding this proposed procedure.
- ❑ I understand smoking is extremely detrimental to the healing process. **I agree to cease all use of tobacco for 6 weeks prior to and 6 months after surgery and to make strong efforts to give up smoking entirely.**
- ❑ Recognizing that during the surgery some unforeseen condition may be discovered that may necessitate a change in approach or different procedure from those explained above, I authorize Dr. Reynolds/Dr. Auble to perform such procedures as are necessary and advisable in the exercise of his professional judgment.
- ❑ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that the treatment would be helpful, and I have weighed the risk with the proposed benefits.
- ❑ I have discussed my past medical history with the doctor and have disclosed **ALL** diseases and medications, including alcohol and drug use past and present.
- ❑ I agree to cooperate completely with the recommendations of Dr. Reynolds/Dr. Auble, realizing that lack of cooperation may result in a less than optimal result.
- ❑ I have reviewed / viewed pre-operative and post-operative instructions.
- ❑ I understand that oral hygiene will be difficult following surgery, but will do my utmost to follow normal tooth brushing and oral hygiene routines.

I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made, and that all blanks or statements requiring completion were filled in, and any inapplicable paragraphs were stricken before I signed. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the procedure.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date