REYNOLDS ORAL & FACIAL SURGERY

CONSENT FOR DISTRACTION OSTEOGENESIS SURGERY OF AN ALVEOLAR SEGMENT (TOOTH BEARING PART OF JAW BONE)

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):_____
- ❑ These procedures are necessary to treat the following condition(s):Loss of bone of the jaws that is normally tooth bearing (alveolar bone) in the area of teeth # _____ ; ❑ right; ❑ left; ❑ upper; ❑ lower jaw (check correct area(s)).
- ❑ The possible alternate methods of treatment (if any), include:_____
- ❑ I understand the surgical procedure planned to treat the above condition and the nature of the treatment to be creating a bone cut or cuts (osteotomy); placing the distraction device(s) which will later be activated to stretch and grow bone.
- ❑ 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:
  - ❑ Facial and jaw swelling after surgery, usually lasting several days.
  - ❑ Bleeding, both during and after surgery, which may sometimes be severe.
  - ❑ Allergic reaction to any of the medications given during or after surgery.
  - ❑ Delayed healing or non-union of the bony segments, possibly requiring a second surgery and/or bone graft to repair.
  - ❑ Premature fusion (osteosynthesis) of the bony parts that are to be moved and lengthened by this procedure, possibly requiring additional surgery.
  - ❑ Relapse: the tendency for the repositioned bony segments to return to their original position, which may require additional treatment, including repeat surgery and/or bone grafting. The degree of relapse and predictability of long-term stability after distraction osteogenesis surgery is uncertain.
  - ❑ Bruising and discoloration of the skin.
  - ❑ Loss of feeling, pain or tingling in the lips, chin, tongue (including possible loss of taste sensation), cheeks. These symptoms may last for days, weeks or months. In certain cases, the altered sensation may be permanent.
  - ❑ Scarring from incisions or areas where external pins or distraction devices may pass through the mucosa.
  - ❑ Jaw joint (TMJ) symptoms such as clicking, locking and discomfort may be present during and after the planned procedure.
  - ❑ Changes in bite (malocclusion) that may require prolonged orthodontic treatment to attempt correction.
  - ❑ Tooth and gum (periodontal) complications including: tooth movement, damage to tooth roots adjacent to the bone cut, possibly involving future root canal therapy or even loss of teeth, gum recession and pocketing and other dental complications.
  - ❑ If bone grafting is contemplated, you will be asked to sign a separate consent form for that procedure.
  - ❑ In upper jaw surgery, the sinuses may be affected for several weeks and there may be the need for further therapy, including sinus surgery, to remedy any lingering problems.
  - ❑ Post-operative infection which may cause loss of adjacent bone and/or teeth and which may require care for a prolonged period of time.
  - ❑ Stretching of the corners of the mouth with resulting discomfort and slow healing.
  - ❑ The distraction device may fail under stress and require replacement at any time.

- ❑ 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.
- ❑ Other:_____

❑ If I am personally activating the distraction device (rather than the doctor), I understand that incorrect adjustments can result in less than ideal positioning of the bone segments. If I have any uncertainty about the instructions for self-activation or feel that expected results are not being accomplished or that the device is not responding appropriately, I will notify my doctor immediately.

ADDITIONAL AGREEMENTS AND AUTHORIZATIONS

❑ 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