REYNOLDS
ORAL & FACIAL
SURGERY

CONSENT FOR ORTHOGNATHIC SURGERY

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

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

- ❑ I understand that Orthognathic surgery is being planned for me. I understand the benefits and risks of such surgery. This is NOT minor surgery and I have been informed about my condition and the recommended treatment options.
- ❑ I authorize Dr. Reynolds to perform the following procedure(s):_____
- ❑ These procedures are necessary to treat the following condition(s):_____
- ❑ The possible alternate methods of treatment (if any), include:_____
- ❑ Dr. Reynolds will be assisted by:_____
- ❑ I understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative 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 enough to require blood transfusion. I have been advised of the opportunity for blood donation before surgery so that my own blood may be given back to me (autotransfusion) if necessary.
    - ❑ Allergic reaction to any of the medications given during or after surgery.
    - ❑ Delayed healing of the bony segments; rarely requiring a second surgery and/or bone graft to repair.
    - ❑ Relapse: the tendency for the repositioned bone segments to return to their original position, which may require additional treatment, including surgery and/or bone grafting.
    - ❑ Bruising and discoloration of the skin around the jaws, eyes and nose.
    - ❑ Diminished sense of smell (if upper jaw surgery is done).
    - ❑ A change in cosmetic appearance. Although this is primarily a procedure to restore jaw function, I am aware of some expected change in my appearance. I understand that certain cosmetic changes may not be totally predictable. There may also be changes in speech patterns which may require additional treatment.
    - ❑ Injury to the nerve resulting in numbness or pain in the lower lip, chin, tongue (including loss of taste sensation), cheek, gum, lower front teeth and area of the donor or recipient site, or more extensive areas, which may be temporary or permanent.
    - ❑ Possible decreased function of muscles of facial expression.
    - ❑ Scarring from external skin incisions if certain rigid fixation methods are used.
    - ❑ Possible need for additional procedures to remove fixation devices, pins, screws, plates or splints.
    - ❑ In certain cases where bone cuts may be made in the marrow space between teeth, there is the possibility of devitalization of those teeth which may require later root canal procedures, and may result in the loss of those teeth.
    - ❑ In upper jaw surgery, the sinus will be affected for several weeks, and there may be a need for further sinus surgery to remedy any lingering problems.
    - ❑ Post-operative infection which may cause loss of adjacent bone and/or teeth and which may require additional treatment for a prolonged period of time.
    - ❑ Change in position of the jaw joints (TMJ) which may cause post-operative discomfort, bite change and chewing difficulties. If TMJ symptoms existed before surgery, there may be no improvement and even some worsening of these symptoms after surgery.
    - ❑ Stretching of the corners of the mouth with resulting discomfort and slow healing.
    - ❑ Inflammation of veins (phlebitis) that are used for IV fluids and medications, sometimes resulting in pain, swelling, discoloration and restriction of arm or hand movement for some time after surgery.
- ❑ General anesthesia will be used for this surgery and I have been told of the risks, including bronchitis, pneumonia, hoarseness or voice changes, cardiac irregularities, heart attack or death. I am aware of the importance of not having anything by mouth (including clear liquids unless specifically authorized by my doctor or anesthesiologist) FOR SIX (6) HOURS PRIOR TO MY ANESTHETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING.**

- ❑ I realize the importance of providing true and accurate information about my health, especially concerning possible pregnancy, allergies, medications and history of drug or alcohol use. If I misinform my doctor I understand the consequences may be life-threatening or otherwise adversely affect the results of my surgery. 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 understand smoking is extremely detrimental to the success of any surgery. **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.**
- ❑ If my teeth are wired together after this surgery, I understand there are certain associated risks and complications: oral hygiene will be diminished, there may be resulting gum disease, my teeth will feel slightly loose for some time after the wiring, and there is always some concern about airway obstruction. I agree to carry wire cutters with me at all times when my jaws are wired and to avoid the use of alcohol and other activities that may cause nausea or airway problems.
- ❑ 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 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 agree to cooperate completely with the recommendations of Dr. Reynolds, 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 understand that the images I have seen are purely for purposes of illustration and discussion and that the final outcome of my surgery may not match those illustrations. I realize that surgery is not an exact science and results depend upon many factors, including my individual healing characteristics.
- ❑ Dr. Reynolds has made it clear that there may be no specific relationship between the computerized images and my final surgical result. Differences may occur despite his best efforts, or due to conditions or events beyond control of surgeon, staff, or other persons involved in my surgery.
- ❑ **I ACKNOWLEDGE THAT THERE IS NO WARRANTY OR GUARANTEE EXPRESSED OR IMPLIED AS TO MY FINAL APPEARANCE BY THE USE OF THE COMPUTERIZED IMAGING DEVICE.**

INFORMATION FOR FEMALE PATIENTS

I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

CONSENT

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