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ORAL & FACIAL
SURGERY

CONSENT FOR SINUS LIFT/BONE GRAFTING PROCEDURE

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):Bone Grafting into the floor of the RIGHT/LEFT maxillary sinus in order to increase the bone available for implants.
- ❑ These procedures are necessary to treat the following condition(s): enlarged maxillary sinus and or alveolar bone loss in the RIGHT/LEFT upper jaw
- ❑ The possible alternate methods of treatment (if any), include: _____
- ❑ I understand that incisions will be placed inside my mouth in the upper jaw for the purpose of placing bone graft into the maxillary sinus. I acknowledge that the doctor has explained the procedure, including the number and location of incisions.
- ❑ In my case, I further understand that there is not enough natural jawbone in which to place the proposed implant and that a procedure called a maxillary augmentation antroplasty "sinus lift" is planned. This involves opening the sinus cavity in my upper jaw and placing a bone graft in order to provide support for implant(s). I have been told that this graft could come from specially-prepared donated bone, or may be taken from my jaw, chin, skull or hip, any of which might be supplemented with specially-prepared donated bone or bone substitute.
- ❑ It has been explained to me that once the one graft is inserted, **the entire treatment plan must be followed and completed on schedule**. If this is not done, the bone graft may fail.
- ❑ I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me.
- ❑ 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:
  - ❑ Post-operative discomfort and swelling that may require several days of at-home recuperation.
  - ❑ Prolonged or heavy bleeding that may require additional treatment. Because the sinus is involved, some bleeding may be from the nose.
  - ❑ Injury or damage to adjacent teeth or roots of adjacent teeth, possibly requiring further root canal therapy, and occasionally the loss of an injured tooth.
  - ❑ Post-operative infection, including sinus infection that may require additional treatment. In rare instances an opening may develop between mouth and sinus, again requiring additional treatment.
  - ❑ Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.
  - ❑ Restricted mouth opening for several days; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ).
  - ❑ Possible prolonged symptoms of sinusitis requiring certain medications and longer recovery time, resulting from intentional entry into the sinus.
  - ❑ Fracture of the jaw.
  - ❑ Possible injury to nerve branches in the bone resulting in numbness, pain or tingling of the lips, cheek, gums or teeth. These symptoms may persist for several weeks, months or, in rare instances, may be permanent.
  - ❑ Swelling and discomfort and some difficulty chewing and swallowing for a time.
  - ❑ Occasionally, grafted material will migrate into surrounding tissues and require further treatment. Although uncommon, graft material may press against nerve structures, causing enough discomfort that some or all the graft may require removal.
  - ❑ Post-operative infection that may require additional treatment, including loss of the graft.

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- ❑ Wound opening that may result in loss of the graft.
- ❑ Other:_____
- ❑ Bleeding, swelling or infection at the donor site requiring further treatment.
- ❑ Allergic or other adverse reaction to drugs used during or after the procedure.
- ❑ The need for additional or more extensive procedures in order to obtain sufficient bone for grafting.

RISKS OF FREEZE-DRIED, DEMINERALIZED OR OTHER BANKED BONE

- ❑ On occasion, additional donated bone is used to supplement the patient's bone, or to spare an extensive donor site surgical procedure. Use of such bone may involve separate risks including, but not limited to:
- ❑ Rejection of the donated graft material together with the entire graft.
- ❑ The remote chance of disease transmission from processed bone.
- ❑ I understand that in my grafting procedure, the use of (autogenous, demineralized, etc.) bone is expected to be taken from (note anatomic area), plus (other area)

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