

# REYNOLDS ORAL & FACIAL SURGERY



## CONSENT FOR BONE GRAFT SURGERY

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_

### PLEASE CHECK EACH BOX AFTER READING.

- I authorize Dr. Reynolds/Dr. Auble to perform bone grafting which is intended to place bone in the \_\_\_\_\_ area.
- These procedures are necessary to treat the following condition(s): \_\_\_\_\_
- The possible alternate methods of treatment (if any), include: \_\_\_\_\_
- The Bone Graft Material will be;
  - Autograft – from donor site;
    - tuberosity (maxilla)  lateral mandible  chin  hip (iliac)  leg (tibia)  skull (cranium)
  - Allograft - Human Donor Bone
  - Xenograft -Bovine or C-graft
  - Alloplast - Biogran/Perioglass/Bioplast/Cerasorb
  - Bone - Morphogenetic Protein (rhBMP-2/ACS)

In addition to the risks of the primary surgical procedure that have been explained to me separately, I understand that bone grafting itself involves specific risks. I understand that such risks include, but are not limited to, the following:

### GENERAL RISKS

- Bleeding, swelling, infection that may require further treatment or hospitalization.
- Scarring, pain, numbness or altered sensation (possibly permanent) at the surgical site or the donor site.
- Allergic or other adverse reaction to the drugs used during or after the procedure.
- The need for additional or more extensive procedures in order to obtain sufficient bone mass at the intended site.
- Loss of bone particles from donor or recipient sites for some time after surgery.
- Loss of the bone graft due to infection, poor healing, or other reason.
- Fracture at the donor site.
- Hematoma requiring further treatment and hospitalization.

### RISKS AND COMPLICATIONS OF GRAFTING FROM WITHIN THE MOUTH AREA

- Damage to adjacent teeth or fillings that may require future root canal procedures, or may cause loss of those teeth.
- Injury to the lips from surgical instruments.
- Removal of adult teeth in order to obtain sufficient bone material.
- 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.
- Penetration of the sinus or nasal cavity in the upper jaw, which could result in infection or other complication requiring additional drug or surgical treatment.
- Restricted mouth opening for several days or weeks from stress on the jaw joints (TMJ). Existing TMJ problems may be worsened.
- Exposure of bony fragments or prominences coming through the gums after surgery during the healing phase which may require further surgery.

### RISKS AND COMPLICATIONS OF BONE GRAFTING FROM THE HIP REGION

- Numbness, burning and/or pain of the hip, thigh or buttocks, temporary or permanent.
- Gait disturbance - inability to walk normally that may be temporary or permanent.
- Perforation into the abdominal cavity requiring further treatment and hospitalization.
- Sciatica - radiating pain to the legs from irritation of the sciatic nerve that may persist.
- Unightly scarring at the incision site which may remain so despite efforts at later revision.

### RISKS AND COMPLICATIONS OF BONE GRAFTING FROM THE LEG REGION

- Numbness, burning and/or pain of the leg or area where the graft is taken, temporary or permanent.
- Gait disturbance - inability to walk normally - which may be temporary or permanent.

- Unsightly scarring at the incision site which may remain so despite efforts later.

**RISKS AND COMPLICATIONS OF BONE GRAFTING FROM THE RIBS**

- Penetration of the lung cavity with need for insertion of tubes to drain the chest and expand the lungs and continued care for this complication.
- Numbness in the area of donor site surgery (or more extensive areas), temporary or permanent.
- Unsightly scarring at the incision site which may remain so despite efforts later.
- Soreness of donor area for a prolonged time that may restrict mobility and activity.

**RISKS AND COMPLICATIONS OF BONE GRAFTING FROM THE SKULL**

- Shaving of hair from portions of the scalp that may grow in differently from surrounding hair.
- Scars from the incisions that may become more noticeable with hair loss in later life.
- Numbness of certain areas of the scalp that may be temporary or permanent.
- Decreased function of certain muscles of facial expression, notably an inability to furrow the brow or raise the eyebrows normally, which may be temporary or permanent.
- Wound infection or breakdown requiring further treatment.
- Bleeding of scalp or deeper vessels that may require further treatment.
- Subdural hematoma, cerebrospinal fluid leak, meningitis or damage to membranes surrounding the brain that may have neurologic consequences requiring hospitalization and further care by a specialist.
- Contour abnormalities or bony irregularities of the skull that, although hidden by hair, may have cosmetic effects.

**HUMAN DONOR BONE (Allograft) or BONE SUBSTITUTES (Xenograft [Bovine or C-graft] Alloplast [Biogran/Perioglass/Bioplant])**

On occasion, additional donated, processed, or artificial bone substitutes are used to supplement the patient’s bone, or to spare an extensive graft harvesting procedure. If used, such materials may have separate risks including, but not limited to:

- Loss of the donated or artificial graft material.
- The remote chance of viral or bacterial or prion disease transmission from processed bone. (Allograft and Xenograft)
- Failure of the patients bone to grow into and surround the graft (failure of osseointegration).

**ADDITIONAL AGREEMENTS AND AUTHORIZATIONS**

\_\_\_\_\_ (Initial) I understand smoking is extremely detrimental to the success of this surgery. **I state that I have ceased all use of tobacco for at least 6 weeks prior to surgery. I agree to cease all use of tobacco for 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 surgery.

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Patient’s (or Legal Guardian’s) Signature \_\_\_\_\_ Date \_\_\_\_\_

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Doctor’s Signature \_\_\_\_\_ Date \_\_\_\_\_

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Witness’ Signature \_\_\_\_\_ Date \_\_\_\_\_