REYNOLDS
ORAL & FACIAL
SURGERY

CONSENT FOR CORTICAL ONLAY BONE GRAFTING

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): *CORTICAL ONLAY BONE GRAFTING*_____
- ❑ These procedures are necessary to treat the following condition(s):_____
- ❑ The possible alternate methods of treatment (if any), include:_____
- ❑ The procedure necessary to treat the condition has been explained to me as *CORTICAL ONLAY BONE GRAFTING*. This involves taking a segment of bone from the front of the chin or lateral aspect of the jaw bon, or hip or skull area and transferring it to the site(s) where bone support has been determined to be deficient (usually for placing a dental implant).
- ❑ 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 requiring several days of at-home recovery.
  - ❑ Prolonged or heavy bleeding that may require additional treatment.
  - ❑ Injury or damage to the blood supply of teeth adjacent to the graft donor site. That may require root canal treatment of affected tooth, or even result in their eventual loss.
  - ❑ Post-operative infection that my adversely affect the new bone graft and require additional treatment.
  - ❑ Scarring at the site of incisions inside the mouth, which also may have cosmetic effects on the skin.
  - ❑ Osteomyelitis, a chronic bone infection at either donor or recipient graft site, which may require long-term antibiotic therapy or other treatment.
  - ❑ 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.
  - ❑ Fracture of the jaw.
  - ❑ Injury to sensory nerves in either donor or recipient sites, resulting in numbness, tingling, pain, or other sensory disturbances in the chin, lip, cheek, face, teeth, gums or tongue, and which my persist for several weeks or months, or rarely may be permanent.
  - ❑ Failure of the graft to integrate with natural bone, loss of vitality or other unexpected loss of the bone graft.
  - ❑ To supplement the cortical graft, natural particles of donor bone, or other forms of synthetic bone are often packed around the cortical graft. These particles may also become devitalized and be lost, often over some period of time.
  - ❑ Biologic/synthetic membranes are often used to contain and protect the graft. Some may require a second procedure to remove them; or some may be unexpectedly lost in which case the graft may be adversely affected.
  - ❑ This grafting procedure is planned in two stages: one to take and place the graft, then a second to remove various fixation devices (screws, wires, membranes). If planned, dental implants may be placed at the second stage, or weeks or months of further healing may be required before the bone graft is sufficiently mature to place implants.
  - ❑ Allergic reactions (previously unknown) to any medications used in treatment.
  - ❑ I understand that I must commit to timely placement of the planned dental implant. If too much time passes, the bone graft may resorb ("melt away") and the resulting deficient bone will not permit implant placement.

ADDITIONAL AGREEMENTS AND AUTHORIZATIONS

REYNOLDS
ORAL & FACIAL
SURGERY

- ❑ 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