REQUEST FOR TREATMENT AND CONSENT

"SANDWICH GRAFT OPERATION"

MAXILLARY(UPER JAW) RIDGE SURGERY WITH BONE REPLACEMENT GRAFTING AND POSSIBLE PLACEMENT OF IMPLANTS FOR :

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Dr ._____ has explained to me the various steps involved in my proposed surgery. Alternative treatment plans have been discussed ,and I feel comfortable in proceeding with the outlined surgery.

The following are some facts which pertain to my surgery which have been explained to me.

I understand that the surgery will be performed to place a bone graft material on top and within the crestal bone of the upper jaw. The bone graft will be "sandwiched" between the existing bone. Dr. _____ has explained how this operation will be performed to my satisfaction. The graft material will consist of a bone substitute material (hydroxylapatite), tissue back bone or combination of both. In approximately five to six months, after the graft has partially healed, a second procedure will be done to insert the implants into the upper jaw and the grafted material. In some cases it is possible to insert the implant and graft in the same operation. It is expected that the implants will become stable and act as placed in an attempt to either change the contour of the bone ridge, make it wider, or make it larger.

The graft material consists of small particles. Some of the particles may work loose during the initial healing period. However this should not influence the success of the surgery and the particles will do no harm if swallowed.

Following the graft, it is sometimes necessary to have a second procedure called a vestibuloplasty. This operation provides more tissues to cover the grafted ridge.

A custom surgical split may need to be attached to the jaw(using surgical wire , surgical screw or sutures) for 1 to 4 weeks to help keep the synthetic bone graft in place and to form it properly to jaw bone. The patients existing partial denture or full denture can sometimes be modified for this purpose.

The surgical techniques have been explained to me in detail. I understand that just like in any other surgery complications can occur, including but not limited to infection, bleeding, tissue damage, permanent numbness of the upper lip, face or cheeks, and loss of the graft, (requiring future surgical procedures).

ICOI: INTERNATIONAL CONGRESS OF ORAL IMPLANTOLOGISTS

IMPLANT PATIENT INFORMATION AND CONSENT FORM FOR :

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1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum of in the bone.
2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.
3. I have been further informed of the possible risks and complications involved with the surgery, drugs, and anesthesia. Such complications include pain, swelling , infection and decolouration. Numbness of lip, tongue, chin , cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible inflammation of a vein, injury to teeth present , bone fractures , sinus penetration, delayed healing , allergic reactions to drugs or medications used, etc.
4. I understand that if nothing is done , any of the following could occur: bone disease , loss of bone , gum tissue inflammation , infection , sensitivity, looseness of teeth followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.
5. My doctor has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient following the placement of implant.
6. It has been explained that in some instances implants fail and must be removed. I have been informant and understand the practice of dentistry is not an exact science; no guarantee or assurance as to the outcome of the results of treatment of surgery can be made.
7. I understand that excessive smoking, alcohol, or sugar may affect gum healing and may limit the success of implant. I agree to follow my doctor’s homecare instructions. I agree to report to my doctor for regular examinations as instructed.
8. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle of hazardous device for atleast 24 hours of more until fully recovered from the effects of the anesthesia or drugs given for my care.
9. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
10. I consent to photography, filming , recording , and x-rays of the procedure to be performed for the advancement of imp dentistry, provided my identity is not revealed.
11. I request and authorize medical/ dental services for me, including implants and other surgery. I fully understand that during and following the complicated procedure, surgery, or treatment , conditions may become apparent which warrant , in the judgment of the doctor, additional or

alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care , if it is felt this is for my best interest.

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Patient name	Date	Signature of doctor	Date
_____		_____	
Signature of patient	Date	Signature of witness	Date