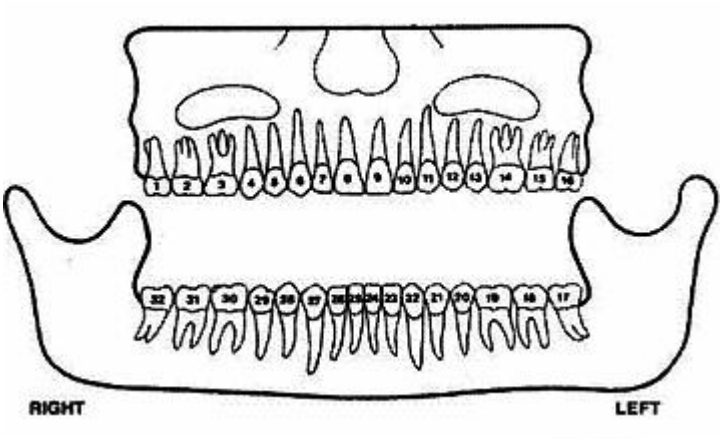
CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY AND ANESTHESIA

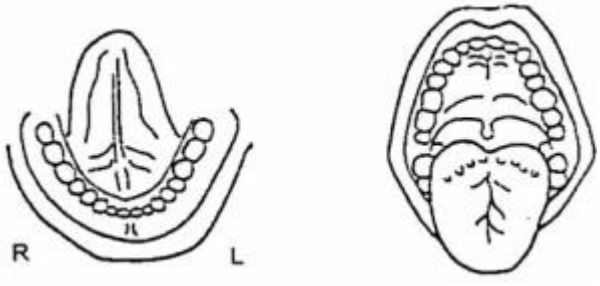
DIAGNOSIS_____

SURGICAL PROCEDURE_____

ALTERNATIVES TO TREATMENT_____

POSSIBLE RISKS OR COMPLICATIONS THAT HAVE BEEN EXPLAINED TO ME INCLUDE BUT ARE NOT LIMITED TO:





- ☐ "Dry socket" or slow healing of an extraction site
- ☐ You may experience local swelling, bleeding, bruising, and/ or pain after the procedure
- ☐ Possible infection and/or hospitalization and/or death and/or referral to a specialist for further treatment
- ☐ Injury to nerves in or around the mouth that could cause temporary or permanently numb lips, chin, tongue, or loss of taste sensation.
- ☐ Decision to leave a small piece of root in the jaw when it's removal would require extensive surgery and an increased risk of complications
- ☐ Sinus involvement that may require surgery at a later date
- ☐ Injury to nearby teeth, soft tissue, or fillings
- ☐ Sore jaw or restricted mouth opening or jaw joint problems
- ☐ Unusual reaction to medications given or prescribed
- ☐ Impaired healing of the bone due to drugs (i.e., bisphosphonates), radiation therapy, or infection
- ☐ ANESTHETIC RISKS: include discomfort, rapid pulse, swelling, bruising, infection, anxious feelings, allergic reactions, and lip chewing. Anesthetics occasionally are not effective in some patients
- ☐ Tipping or Drifting of the permanent teeth or supra eruption of the opposing teeth
- ☐ Swallowing/aspirating of tooth, fillings, crowns, or pieces of tooth
- ☐ Other _____

RISK TO MY HEALTH IF THIS PROCEDURE IS NOT PERFORMED INCLUDE, BUT ARE NOT LIMITED TO:

- ☐ Pain
- ☐ Infection
- ☐ Cyst or tumor formation in the area of infected tooth
- ☐ Loss of bone around the teeth causing their loss
- ☐ Increased risk of complications if surgery is postponed to a later date
- __ Possible delay of permanent tooth eruption
- __ Other _____

A perfect result from recommended treatment cannot be guaranteed. If unexpected problems arise during the procedure the doctor will do what is deemed necessary to correct the condition. Medications given or prescribed for pain may cause drowsiness.

PATIENT IDENTIFICATION:

PATIENT CONSENT:

I consent and understand to the above procedure and agree to cooperate with Dr._____ I will follow post-operative instructions to the best of my ability for my own comfort and safety. I have had an opportunity to ask questions about the above treatment. I have been counseled not to drive or perform hazardous chores until I have recovered from the effects of these medications.

I do/do not consent to the disposal of my teeth by qualified authorities and the use of my extracted teeth for scientific or educational purposes.

_____ _____

Patient, Parent, Guardian Date

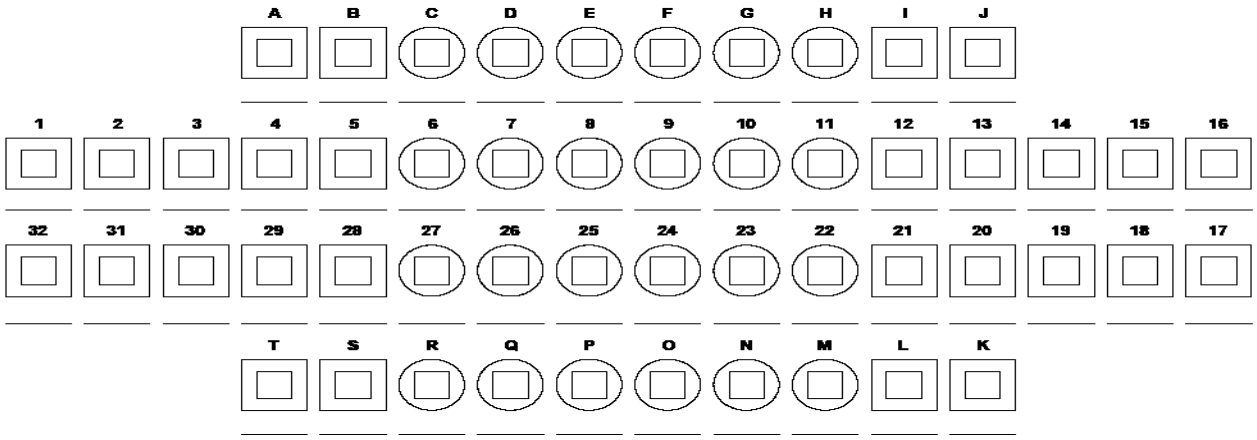
_____ _____

Doctor (who obtains consent) Witness or Interpreter

Dept. Health and Human Services, Indian Health Service

UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE AND WRONG PERSON SURGERY

DENTAL EXTRACTIONS



"Time Out" Documentation

BY ACTIVE VERBAL COMMUNICATION:
Document a ✓ for a YES or N/A if the item does not apply.

_____The correct patient has been identified using two patient identifiers

_____The correct side and site have been identified

- Check that the radiographs are properly oriented and visually confirm that the correct teeth or tissues have been charted
- Mark the diagram above to indicate which tooth/teeth are to be extracted by placing an **X** on the line below the diagram of the tooth/teeth to indicate a plan for extraction. NOTE: Marking of the actual tooth/teeth is not a requirement of the Universal Protocol.

_____The correct procedure is about to begin

_____ Availability of any special equipment or special requirements

Signatures verify Universal Protocol completed just before the procedure began with active verbal participation of the operative team.

Surgeon/Dentist/Provider Date/Time

Dental Assistant Staff Date/Time

Patient Identification