CONSENT FOR DISTRACTION OSTEOGENESIS SURGERY

Patient' Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

The surgery planned for you is somewhat complicated and it is important that you understand the nature of the procedure(s) and the benefits and risks of such surgery. You have the right to be fully informed about your condition and the recommended treatment plan. This is NOT minor surgery and the disclosures in this consent are not meant to alarm you, but rather provide information you need in order to give or withhold your consent to the planned surgery.

_____1. I hereby authorize Dr._____and staf f to treat the condition described as:_____
_____

_____2. The surgical procedure planned to treat the above condition has been explained to me, and I understand the nature of the treatment to be:_____
_____

_____3. I have been informed of possible alternative forms of treatment (if any), including orthognathic surgery, bone grafting and/or:_____
_____
_____

_____4. My doctor has explained that there are certain potential risks and side effects of my planned surgery, some of which may be serious. They include, but are not limited to the following:

_____ A. Facial and jaw swelling after surgery, usually lasting several days.
_____ B. Bleeding, both during and after surgery, which may sometimes be severe enough to require blood transfusion. I have been advised of the opportunity for blood donation before surgery so that my own blood may be given back to me (auto-transfusion) if necessary.
_____ C. Allergic reaction to any of the medications given during or after surgery.
_____ D. Delayed healing or non-union of the bony segments, possibly requiring a second surgery and/or bone graft to repair.
_____ E. Premature fusion (osteosynthesis) of the bony parts that are to be moved and lengthened by this procedure, possibly requiring additional surgery.
_____ F. Relapse: the tendency for the repositioned bony segments to return to their original position, which may require additional treatment, including repeat surgery and/or bone grafting. The degree of relapse and predictability of long-term stability after distraction osteogenesis surgery is uncertain.
_____ G. Facial asymmetry may occur from greater lengthening of the bone on one side relative to the other, possibly requiring additional surgery.

_____ H. Bruising and discoloration of the skin in any of the facial, scalp or neck regions.

_____ I. Diminished sense of smell (if upper jaw or mid-face surgery is done).

_____ J. Eye injuries (if upper jaw or mid-face surgery is done) including blindness, corneal injuries, dry eyes, changes in tear flow, eversion of the lower eyelid (ectropion); some of which may require additional treatment, including possible surgery.

_____ K. Loss of feeling, pain or tingling in the lips, chin, tongue (including possible loss of taste sensation), cheeks, forehead, or any region of the face, scalp or neck, which occurs in a significant number of patients. These symptoms may last for days, weeks or months. In certain cases, the altered sensation may be permanent.

_____ L. Possible decreased, or loss of, function of muscles of facial expression that may be temporary or permanent.

_____ M. Scarring from external skin incisions or areas where external pins or distraction devices may pass through the skin. In the case of external devices, the scarring involves all layers of the skin and underlying tissues and may require surgical revision.

_____ N. If cranial fixation devices are used, there is a risk of brain injury or infection from the fixation pins placed in the skull; also discomfort, disruption of normal activities, scarring, hair loss and numbness in the area of the external pins.

_____ O. Jaw joint (TMJ) symptoms such as clicking, locking and discomfort may be present during and after the planned procedure.

_____ P. Changes in bite (malocclusion) that may require prolonged orthodontic treatment to attempt correction.

_____ Q. Tooth and gum (periodontal) complications including: tooth movement, damage to tooth roots adjacent to the bone cut, possibly involving future root canal therapy or even loss of teeth, gum recession and pocketing and other dental complications.

_____ R. Changes in speech patterns may result, possibly requiring speech therapy.

_____ S. If bone grafting is contemplated, you will be asked to sign a separate consent form for that procedure.

_____ T. In upper jaw surgery, the sinuses may be affected for several weeks and there may be the need for further therapy, including sinus surgery, to remedy any lingering problems.

_____ U. Post-operative infection which may cause loss of adjacent bone and/or teeth and which may require care for a prolonged period of time.

_____ V. Stretching of the corners of the mouth with resulting discomfort and slow healing.

_____ W. Inflammation of veins (phlebitis) that are used for IV fluids and medications, sometimes resulting in pain, swelling, discoloration and restriction of arm or hand movement for some time after surgery, possibly requiring additional treatment.

_____ X. The distraction device may fail under stress and require replacement at any time.

_____ Y. Other:_____

_____5. General Anesthesia will be used for this surgery and I have been told of the risks, including bronchitis, pneumonia, hoarseness or voice changes, cardiac irregularities, heart attack or stroke during anesthesia. I am aware of the importance of not having anything by mouth (including clear liquids), unless specifically authorized by my doctor or anesthesiologist after midnight on the day before surgery. IT IS VITAL THAT I HAVE NOTHING TO EAT OR DRINK FOR **SIX (6) HOURS** PRIOR TO MY ANESTHETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING!** **However,** it is important to take any regular medications (high blood pressure, antibiotics, etc.) or medications provided by this office, **using only a small sip of water.**

_____6. I realize the importance of providing true and accurate information about my health, especially concerning possible pregnancy, allergies, and medications - including holistic medications, herbal remedies and over-the-counter medicines - and history of drug or alcohol use. If I misinform my doctor I understand the consequences may be life threatening or may otherwise adversely effect the result of my surgery.

_____7. If my teeth are wired together after surgery, I understand there are certain associated risks and complications: oral hygiene will be diminished, there may be resulting gum disease, my teeth will feel slightly loose for some time after the wiring is removed, and there is always some concern about airway compromise. I agree to carry wire cutters with me at all times when my jaws are wired and to avoid the use of alcohol, drugs and other activities that may create nausea or risk to my airway.

_____8. If any unforeseen condition should arise during surgery that may call for additional or different procedures from those planned, I authorize my doctor to use surgical judgment to provide the appropriate care.

_____9. If I am personally activating the distraction device (rather than the doctor), I understand that incorrect adjustments can result in less than ideal positioning of the bone segments. If I have any uncertainty about the instructions for self-activation or feel that expected results are not being accomplished or that the device is not responding appropriately, I will notify my doctor immediately.

INFORMATION FOR FEMALE PATIENTS

_____1. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the effect of the pill, allowing pregnancy to result. I agree to consult with my personal physician to initiate additional forms of birth control during the time of my treatment, and to continue those methods until notified by my physician that I may return to the use of birth control pills.

CONSENT

By signing this consent form, I acknowledge that I have read it completely and understand the procedure(s) to be performed, as well as the risks and alternatives to the proposed procedure(s). I have had all my questions answered to my satisfaction. I was under no pressure to sign this form and have made a voluntary choice to proceed with surgery. I am fully aware that no guarantee or warranty can be made regarding the results of treatment. I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date