

**CONSENT FOR TREATMENT OF FACIAL FRACTURES**

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**Patient Name:** <<patient\_first\_name>> <<patient\_last\_name>>      **Date:** <<current\_date>>

It is required that all patients read and sign consent prior to any treatment. In order for you to give your consent to treatment we feel strongly that you, as the patient, should be given as much information as possible regarding that treatment. We have found that our best patients are our most informed patients. This information is not meant to alarm you, but rather allow you to make an informed decision. We also feel that you should have an opportunity to ask questions and receive satisfactory answers to those questions. We ask that you please take your time and read the following form completely.

1. My doctor has explained to me that there are certain potential risks and side effects of my surgery, some of which may be serious. They include, but are not limited to:
  - A. Facial and jaw swelling after surgery, usually lasting several days.
  - B. I understand that bleeding, both during and after surgery, may sometimes be severe enough to require transfusion and/or additional surgery with or without general anesthesia.
  - C. Undesirable side effects of general anesthesia: nausea, vomiting, etc.
  - D. Allergic reaction to any of the medications I may be given during or after surgery.
  - E. A nonunion or malunion of the fractured segments requiring additional surgery to correct.
  - F. Wiring of my upper and lower jaw together during healing, possibly for as long as eight weeks or more. This will definitely affect my diet, may cause temporary weight loss, and adversely affect oral hygiene.
  - G. Bruising and discoloration of the skin around the jaws, eyes and nose.
  - H. I am aware that there may be some loss of feeling or a tingling numbness in my chin, lips, tongue, gingiva (gums), and/or teeth that occurs in a significant number of patients. I understand that this numbness may last for several days, weeks or months, but is expected to return in most cases. I have been told that there is some chance that such numbness may be permanent.
  - I. I have been informed that there is a risk of decreased function or paralysis of the muscles used in facial expression due to damage of the facial nerve and a risk of scarring from external skin incisions.
  - J. I understand that I may need additional procedures to remove fixation, pins, screws, plates and/or splints due to infection or irritation of tissue.
  - K. As in any surgery, there is the potential for postoperative infection which may cause loss of adjacent bone and/or teeth and which may require additional surgery and/or treatment for a prolonged period of time.
  - L. There may be a change in the position of the jaw joints (TMJ) that may cause postoperative discomfort, bite changes, stiffness, and chewing difficulties. If TMJ problems existed before surgery, there may be no improvement and even some worsening of these symptoms after surgery.

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- M. Stretching of the corners of the mouth with resulting in cracking and bruising.
  - N. I have been told of the risks of and consent to the administration of general anesthesia. Possible risks include soreness, redness, swelling, and/or bruising at or around the IV site or along the vein that may require additional treatment. Allergic reaction to medications, bronchitis, pneumonia, hoarseness or voice changes, damage to vocal cords, cardiac arrest or heart attack and/or death may also occur. I also understand that a more thorough explanation of general anesthesia and its associated risks and complications will be discussed with me by the anesthesiologist.
  - O. I am aware that after midnight on the day before surgery I am not to have anything solid or liquid by mouth. **TO DO SO MAY BE LIFE-THREATENING!**
2. Even though I understand that most of the complications listed above are rare, I realize that any of them can and do occur.
  3. I realize the importance of supplying true and accurate information about my health, especially concerning possible pregnancy, allergies, medications, and history of drug or alcohol abuse. I understand that if I misinform my doctor the consequences may be life threatening or otherwise adversely affect the results of my surgery.
  4. If my teeth are wired together after this surgery, I understand there are certain associated risks and complications; oral hygiene will be diminished, there may be some resulting gum disease, my teeth will feel slightly loose for some time after the wiring, and there is always some concern about airway obstruction. I agree to carry wire cutters with me at all times when my jaws are wired and to avoid the use of alcohol and activities that may cause airway problems.
  5. I also understand that following surgery my teeth may not come together exactly as they did before surgery and that orthodontics (braces) and/or occlusal adjustments may be necessary to correct my bite.
  6. While performing my surgery I recognize that my doctor may discover other or different conditions than expected. This may require different or additional procedures than those planned or may, in my doctor's judgment, require termination of my surgery. I authorize Dr. Hornaday to perform such other procedure(s) as he deems medically and/or surgically necessary in his professional judgment or to stop my procedure.
  7. I am also aware that general anesthesia and many drugs are not recommended for elective procedures for women who are pregnant. I understand that it is my responsibility (or the responsibility of a parent or legal guardian of a female patient) to advise my doctor if I am pregnant or possibly could be pregnant.
  8. **I also have been informed by Dr. Hornaday that antibiotics *can* and *may* interfere with the effectiveness of oral birth control pills and that I *can* and *may* become pregnant if another form of contraception is not used. I also understand and have been informed that if antibiotics are used in my care I will need to use another form of contraception and should consult my medical doctor.**
  9. I understand that no warranties or guarantees of any kind have been made to me or anyone about the results of my surgery or procedure(s).

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10. I understand that due to the nature of this procedure that I will need to limit my physical activities including contact sports for up to six months postoperatively.
11. I understand and have been informed that periodic office visits will be necessary after surgery for optimum results and that failure to make these appointments can and may result in an unsatisfactory result and/or need for further procedure(s) and/or surgery.
12. I consent to the taking and publication of photographs in the course of this procedure and I have been assured that my identity will remain anonymous.
13. I have been given adequate opportunity to read this entire form and to ask any questions about my surgery or procedure(s) before signing this form. I understand that it is my responsibility to inform my doctor if I wish to try another method of treatment or if I decide at anytime prior to surgery not to undergo the proposed treatment. I have been informed of the reason for my surgery, the risks and complications involved, and possible alternate methods of treatment, if any, and I elect to undergo the treatment Dr. Hornaday has proposed.
14. By signing this consent form, I acknowledge that I have read it completely and understand the procedure to be performed, the risks and complications, and the alternatives to surgery. I have had all of my questions answered fully. I was under no pressure to sign this form and have made a voluntary choice to proceed with surgery.
15. I understand that I will be asked to sign this form in a digital format and that what I am signing is exactly what I have read on this form. If any content of this form changes I understand that I will be notified and will sign a new form.

Patient or Legal Guardian Signature

Date

Witness Signature

Date

Doctor Signature

Date