TEMPOROMANDIBULAR JAW JOINT SURGERY

Temporomandibular jaw joint surgery includes several different surgical procedures. Your surgeon will go over the specific procedure planned. The following procedures are:

**Arthrocentesis** is the irrigation of the joint. The surgeon injects the joint with local anesthetic and fluid to flush out inflamed fluids. Steroids may also be injected to help combat any inflammation.

**Arthroplasty** refers to all types of open surgery for the temporomandibular joint (TMJ), including disk repositioning, discectomy, and joint replacement.

**Disk repositioning** is used when the protective cartilage disk has slipped out of place inside the TMJ. Under general anesthesia, the surgeon makes an incision, moves the displaced disk back to its original position, and stitches it in place. The surrounding ligaments are also repaired, if needed.

**Discectomy** is used when the disk has deteriorated or has been damaged. Under general anesthesia, the surgeon makes an incision and removes the disc. Scar tissue will eventually completely fill the joint to prevent the bones from rubbing and grinding together.

**Articular eminence (the “socket” portion of the TMJ) recontouring** is used if the articular eminence is too deep or steep. The surgeon shortens and smooths the articular eminence.

**TMJ replacement** is a procedure in which the joint is removed and replaced.

Patient’s Initials

_____ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks, and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of temporomandibular jaw joint surgery have been discussed with me and may include but are not limited to:

- Postoperative swelling, bruising of the area, hematoma (blood clot) formation, and discomfort.
- Postoperative changes in bite after surgery requiring further treatment.
- Wound breakdown or infection of the surgical site.
- Foreign body reaction and/or rejection of materials implanted in the joint.
- Scarring of the incision line, possibly requiring later revision.
- Development of adhesions from scarring within the joint space, which may cause continued jaw dysfunction and decreased range of motion or chewing difficulties.
- Weakness (paralysis) of the facial muscles of the forehead and eyelid, or inability to close the eye tightly on the affected side caused by injury to the motor nerves in or near the surgical site. These complications may be temporary or permanent.
- Possible alteration or loss of taste that could possibly be permanent.
- Possible ear problems, including infection of external, middle or inner ear; hearing loss; ringing in the ears or equilibrium problems, all of which may be temporary or permanent.

_____ I understand and accept that complications, including the remote risk of death or serious disability, exist with any surgical procedure.

_____ I understand and accept the risks of blood transfusion(s) that may be necessary (if applicable).

_____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The surgeon will do his/her best to minimize scarring but cannot control its ultimate appearance (if applicable).

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications (if applicable).

_____ I have informed the surgeon of all my known allergies.
I have informed the surgeon of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

I am aware and accept that no guarantees about the results of the procedure have been made.

I have been advised of the probable consequences of declining recommended or alternative therapies.

I have been informed of what to expect postoperatively, including, but not limited to, estimated recovery time, anticipated activity level, and the possibility of additional procedures.

I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation (if applicable).

Pre- and postoperative photos and/or videos may be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending surgeon (if applicable).

The surgeon has answered all of my questions regarding this procedure.

Information for Female Patients:

I have informed my surgeon about my possible use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate mechanical forms of birth control during the period of my treatment and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ______________________, DDS/DMD/MD, with associates or assistants of his or her choice, to perform the procedure of ______________________ on ______________________ at ______________________ on ______________________ (procedure name) (patient name) (facility name) (right, left, level, body part).

I further authorize the surgeon(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time ______________________ Relationship to Patient ______________________

Print Patient or Legal Representative Name ______________________ Witness Signature/Date/Time ______________________

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient’s legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Surgeon Signature/Date/Time ______________________

____________ copy given to patient _________ original placed in chart initial

initial