ORTHOGNATHIC SURGERY

Orthognathic surgery is a procedure used to correct conditions of the jaw and face related to structure, growth, sleep apnea, or temporomandibular joint (TMJ) disorders, or to correct orthodontic problems that cannot be easily treated with braces. It is also used in treatment of congenital conditions like cleft palate. Bones can be cut and realigned and held in place with either screws or plates and screws.

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 orthognathic surgery have been discussed with me and may include but are not limited to:

- Postoperative facial and jaw swelling after surgery, usually lasting several days.
- Bruising and discoloration of the skin around the jaws, eyes, and nose.
- Allergic reaction to any of the medications given during or after surgery.
- Delayed healing of the bony segments, possibly requiring a second surgery and/or bone graft to repair.
- Possible relapse (the tendency for the repositioned bone segments to return to their original position) that may require additional treatment, including surgery and/or bone grafting.
- Bleeding, during and after surgery, may sometimes require blood transfusion. If bone cuts are made in the marrow space between teeth, there is the possibility of devitalization of those teeth, which may require later root canal procedures, and may result in the loss of those teeth.
- Upper jaw surgery may affect the sinus for several weeks. There may be a need for sinus surgery to correct any lingering problems.
- Postoperative infection that may cause loss of adjacent bone and/or teeth, which may require additional treatment.
- Positional changes in the jaw joints (TMJ) may cause postoperative discomfort, bite change, and chewing difficulties. If jaw joint symptoms existed before surgery, there may be no improvement and possibly some worsening of these symptoms after surgery.
- Discomfort and slow healing may occur from stretching of the corners of the mouth.
- Inflammation of veins (phlebitis) may occur where IV fluids and medications are administered. Pain, swelling, discoloration, and restriction of arm or hand movement may occur for some time after surgery.
- My teeth may be wired together after this surgery. I understand there are associated risks and complications, such as difficulties with oral hygiene, which may result in gum disease; feeling of tooth mobility for some time after the wiring; and possible airway obstruction.
I agree to carry wire cutters with me at all times if my jaws are wired. I agree to avoid the use of alcohol and other activities that may cause nausea or airway problems.

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) the _________________________.

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 ________________________

original placed in chart ________________________ copy given to patient initial initial

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS, and The Joint Commission requirements, if applicable, and legal requirements of your individual state(s).