CORTICAL BONE GRAFTING SURGERY

Cortical bone grafting is a surgical procedure that replaces missing bone using cortical bone, or compact bone, which is one of two main types of bone tissue. Cortical bone is dense and forms the surface of bones, contributing 80 percent of the weight of a human skeleton. It is extremely hard, formed of multiple stacked layers with few gaps.

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 cortical bone grafting surgery have been discussed with me and may include but are not limited to:

- Several days of swelling and discomfort, which will require staying at home before resuming normal activities.
- Bleeding, which can at times be heavy or prolonged and can occasionally require additional treatment.
- Injury or damage to the teeth adjacent to the area where the bone graft is obtained or placed. It is sometimes necessary that one or more of these teeth undergo root canal treatment, and occasionally a tooth may need to be extracted.
- Infection may develop and result in loss of a portion or all of the bone graft. Management of the infection may require additional treatment.
- Extensive scarring can sometimes occur along the incisions through the gums. Occasionally, the scar may be visible through the overlying cheek tissue.
- A chronic (long-term) bone infection called osteomyelitis may occur at either the site from which the bone is obtained or the site to which it is transferred. This type of infection can require long-term antibiotic therapy or other treatment, and, in rare cases, hospitalization.
- The screws or wires used to secure the bone graft may become exposed. In such cases, they may need to be removed. This can ultimately lead to loss of the bone graft.
- Fracture of the jaw bone or the bone graft.
- Injury to the nerves that provide the feeling to the tissues at either the site from which the bone graft was taken or the site to which it was transferred. This can result in a tingling sensation, numbness, pain, or other sensations, which can affect the chin, lip, cheek, the tongue, and gums. The sensations may persist for weeks or months and can occasionally be permanent.
- Possible alteration or loss of taste may occur that could possibly be permanent.
- A bone graft may not “take” in the area to which it has been transferred and may need to be removed. Sometimes particles of natural or synthetic bone are packed around the main graft. These particles can sometimes work their way out of the wound and be lost.
- Membranes of natural or synthetic tissue are sometimes used to cover the graft to protect it. In some cases, another procedure is required to remove the membrane. In other cases, the membrane may become uncovered during healing and need to be removed.
- Patients can sometimes develop allergic reactions to one of the medications or other materials used in their treatment.

_____ 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 authorize and direct __________________________, DDS/DMD/MD, with associates or assistants of his or her choice, to perform the procedure of __________________________ (procedure name) on ______________________ (patient name) at __________________________ (facility name) on the __________ (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

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