CONNECTIVE TISSUE GRAFTING PROCEDURE

Connective tissue grafting is a surgical procedure where tissue is taken from under healthy gum tissue in the palate and placed at the area of gum recession. The subepithelial connective tissue graft is a very common procedure for covering exposed roots.

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 connective tissue grafting procedure have been discussed with me and may include but are not limited to:

- A few days of swelling and discomfort, which may require staying at home before resuming normal activities.
- Bleeding, which can at times be heavy or prolonged and can occasionally require additional treatment.
- Infection may develop and result in loss of a portion or all of the graft. Management of the infection may require additional treatment.
- Injury to the nerves that provide the feeling to the tissues at the site where the graft was taken. This can result in a tingling sensation, numbness, pain, or other sensations of the tissues of the palate. 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.
- The connective tissue graft may not “take” in the area to which it has been transferred and may need to be removed.
- A loss of the gum tissue overlying the site where the graft was taken (soft tissue “slough”) can occasionally occur. In such cases, healing of the area may be prolonged and require maintenance of a soft diet for an extended period.
- 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 doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and of 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 doctor 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 __________________.

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.

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  Patient or Legal Representative Signature/Date/Time

_________________________
Print Patient or Legal Representative Name

I certify that ______ copy given to patient ______ original placed in chart

initial  initial