Consent Form for Facial Bone Reconstruction with Microvascular Surgery

Dental Hospital

Patient Information

Name ..... Age ..... years HN .....

WARD: ..... Scheduled Procedure..... Date.....

I, ..., hereby consent to undergo treatment and/or surgery performed by Dr. ..... and the medical team to address my condition or that of the individual under my guardianship using the following method(s): .....

.....

This procedure can be explained in simpler terms as follows: .....

.....

1. I have received a detailed explanation from the attending dental/ medical team regarding the benefits, risks, and procedural steps of the treatment. I have also been informed of alternative treatment options available, allowing me to make an informed decision. Furthermore, I understand that I have the right to refuse the proposed treatment.
2. Potential complications of microvascular reconstructive surgery including:
   - General complications such as failure of bone or tissue graft integration, surgical site infection, postoperative pain at the surgical site, pressure ulcers on area such as the head, back, or sacrum.
   - Complications related to fibula free flap such as limited movement of the big toe, ankle pain, muscle weakness, altered skin sensation, potential necrosis of muscles and nerves due to inadequate blood supply.
   - Complications related to iliac crest bone graft such as inflammation, swelling and bleeding at the surgical site, fracture of the iliac crest bone, injury to the peritoneum, reduced bowel movement, nausea, vomiting, or abdominal pain, numbness at the surgical site, hernia, abnormal gait, noticeable scar at the surgical site.
   - Other complications .....

.....

I understand and acknowledge that the dental/ medical team cannot guarantee specific results or completely eliminate all risks, despite exercising the highest level of care and caution.

3. The dental/medical team is authorized to modify the treatment plan as necessary to achieve the best possible outcome. Should any treatment failure occur, I accept full responsibility for any associated costs.

4. Financial disclosure

The operating room nurses and benefits department staff have informed me of the treatment costs, including surgical fees, material and equipment costs, hospitalization fees, anesthesia fees, and other essential expenses. Additionally, I have been advised about which expenses are covered and not covered under various healthcare benefits (e.g., universal healthcare coverage, government employee benefits, social security, and local government health schemes).

5. I fully understand and accept all of the above statements without any doubts and am prepared to undergo the prescribed treatment accordingly.

Signature: .....
(.....)
Treating Dentist

Signature: .....
(.....)
Patient / Authorized Representative
Relationship to the patient: .....

Signature: .....
(.....)
Witness

Signature: .....
(.....)
Witness

Date: ..... Time: .....

Note:

1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.