Informed Consent for Periodontal Tissue Grafting

After a careful examination of my dental condition, my dentist has suggested tissue grafting. Tissue grafts are recommended for a number of reasons including: thickening the width of attached gum tissue to protect against infection and to withstand the irritation of chewing; to cover up exposed roots or implants for aesthetics; to cover up exposed sensitive roots; to plump up tissue for denture retention; to plump up tissue for aesthetics around crowns and bridges.

I understand that local anaesthesia will be needed for my procedure. This procedure involves transplanting a thin strip of gum tissue from either the roof of my mouth, from the gum tissue of adjacent teeth, or from a human donor tissue bank. The transplanted tissue is then placed in the proper surgical site, stitches are used to hold it in place and a gum bandage or dressing may be placed over top.

I understand that if I use my own tissue, there will be a second surgical site where the tissue is taken from. Should I use donor tissue, there will only be the one surgical site, and therefore less overall swelling and discomfort. All donor tissue has been vigorously screened against infectious diseases including HIV and has had all rejection properties removed from it. I may receive additional information of the donor tissue if I request it.

I understand that sometimes the graft is partially successful or completely unsuccessful for a number of reasons, such as: medical conditions, smoking, alcohol consumption, clenching and grinding of teeth, poor Oral Hygiene, diet and nutritional problems, physically damaging the grafted area. When healing is complete, partial coverage of the root may indicate success, as it is impossible to predict the final healing outcome. Additional grafting may be necessary if a greater aesthetic result is desired such as full coverage of an exposed root or implant.

I understand that because it is impossible to predict the final outcome, there is no guarantee to the treatment. In most cases the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. I also acknowledge that alternative treatments include: no treatment, continued monitoring for progressive recession, and the modification of technique for brushing my teeth.

The risks and complications associated with tissue grafting include but are not limited to: partial to complete graft failure; infection; bleeding; swelling and pain; facial discoloration; tooth sensitivity; allergic reactions; swallowing of foreign matter. There is no way to accurately predict how my gums and bone will heal.

I understand that the success of tissue grafting also depends on what I do. If I physically damage the graft site by chewing on it or displacing it with my tongue, it will most likely fail. If I fail to rinse daily with the prescribed mouth rinse and keep the area clean, it will not heal properly. If I brush and floss the area before the graft has healed it may fail. If I smoke or consume alcohol the graft may fail. If I forget to follow any additional instructions as outlined to me by the dentist following my procedure it may fail. If I put any pressure on the graft site before the dentist says it is clear to do so it may fail. Long term stability of the graft is also very dependent on my oral hygiene and my habits, and a successful graft may over time appear the same way it did before the graft was first done. I understand that follow-up appointments are very important for the success of tissue grafting.

Informed Consent:

I have read the **Informed Consent for Periodontal Tissue Grafting** document and I understand it completely. I have had the opportunity to ask questions and I am satisfied with all of the answers provided. I accept that the doctors will do their very best to provide me with a successful result, and I accept any complications that may arise from the work. I authorize any local anaesthesia to be used if necessary and any medications that may be useful during and after the procedure. I authorize photos, x-rays or any other viewing of my care and treatment during or after completion to be used for the advancement of dentistry. My identity will not be revealed to the general public without my permission.

Area(s) to be grafted: ___________________________________

Type of Grafting: ______________________________________

Tissue to be used: Autograft (my own tissue) Allograft (donor tissue)

___________________________	_________________________________	_________________
Patient Name (Printed)	Patient/Guardian (Signature)	Date
___________________________	_________________________________	_________________
Doctor’s Signature	Witness	Date