

## **SOFT TISSUE GRAFTING (Free Connective Tissue)**

**PURPOSE OF SOFT TISSUE GRAFTING SURGERY:** I have been informed that in areas of my upper and/or lower gums around my teeth, that I have either an inadequate amount of fixed gum tissue (attached gingiva) that a Free Gingival Graft has been recommended, or that I have recession that is either sensitive to hot and cold, exposed roots that are prone to cavities, or that I don't like the look esthetically, that a Connective Tissue Graft has been recommended.

**DESCRIPTION OF THE PROCEDURE:** After anesthetics have numbed the area to be operated, the gum is reflected from the jawbone surface, the soft tissue graft is placed on this surface. Finally, the graft and gum is sutured in place.

**DESCRIPTION OF THE GRAFT MATERIAL:** The soft tissue graft can be from one of the three following sources: (1) a layer of gum can be removed from the surface of the gum in the roof of my mouth; (2) a piece of connective tissue from the internal structure of the gum in the roof of my mouth can be harvested through an incision in the palatal gum, after which the incision is sutured closed; (3) a piece of soft tissue donated by the next of kin of deceased persons can be used. All donors are screened by physicians and other health care workers to prevent the transmission of disease to the person receiving the graft. They are tested for hepatitis, venereal disease, blood and tissue infections, and the AIDS virus. Tissue is recovered and processed under sterile conditions. Processing includes preservation by the process of freeze-drying.

**RISKS RELATED TO THE PROCEDURE:** Risks related to surgery with gum tissue regeneration by the use of soft tissue grafts might include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the palate, lip, chin or gum; jaw joint injuries, or associated muscle spasm; transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold or sweets or acidic foods, shrinkage of the gum upon healing. Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness or discoloration at the site of injection of anesthetics.

**ALTERNATIVES TO THE PROCEDURE:** These may include: (1) no treatment, in which the recession may continue with increased loss of bone support and the eventual loss of teeth; (2) placing dental materials over the exposed root structures to decrease the sensitivity; (3) consultation with a periodontist to determine if any other procedures are recommended.

**NO WARRANTY OR GUARANTEE:** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in eradicating gum recession. It is anticipated that the surgery will

provide some improvement in the condition that exists. Due to individual patient differences,

however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, despite the best of care. In addition, because patient compliance following the surgery is of paramount importance to the success of soft tissue grafting, it is difficult to ascertain if failure was due to a lack or disregard to patient compliance.

**CONSENT TO UNFORESEEN CONDITIONS:** During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include but are not limited to, use of other forms of soft tissue grafts or procedures or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

**COMPLIANCE WITH SELF-CARE INSTRUCTIONS:** I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery so that healing may be monitored and the doctor can evaluate and report on the success of surgery.

**SUPPLEMENTAL RECORDS AND THEIR USE:** I consent to photography, video recording and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed. All photos or videos will be limited to the mouth.

**PATIENT'S ENDORSEMENT:** My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. I have had the opportunity to ask questions and they have been answered to my satisfaction. After thorough consideration, I give my consent for the performance of any and all procedures related to soft tissue graft surgery as presented to me during the consultation and treatment plan presentation by Bridge Street Dental Centre or as described in this document.

**Patient Name** \_\_\_\_\_

**Date**\_\_\_\_\_

**Signature** \_\_\_\_\_

**Doctor's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_