



CONSENT FOR DENTAL TREATMENT IN IRRADIATED AREAS (Page 1 of 2)

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing

Patient's Name: _____ Date: _____

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Having been treated previously for cancer with radiation (x-ray therapy to eradicate cancer cells), you should know that there is a significant risk of future complications when dental treatment is planned within those areas. Therapeutic radiation to jaw and facial regions may adversely affect the blood supply to bone, thereby reducing its ordinary excellent healing capacity. This risk is increased after surgery, especially from extraction; implant placement or other "invasive" procedures that might cause even mild trauma to bone. Osteoradionecrosis may result. This is a smoldering, long-term, destructive process in the jawbone that is often very difficult to eliminate.

Your medical/dental history is very important. We must know the total amount of radiation you received during cancer therapy and the exact region(s) where it was applied. An accurate medical history, including names of cancer therapists is important.

If the area of proposed treatment is within the area previously irradiated, it may be advisable or necessary for you to undergo hyperbaric oxygen therapy (HBO) before any invasive procedure. HBO is known to improve blood supply and oxygenation in bone and reduce the risk of post-operative complications – but it is not a guarantee. HBO is performed in a special atmospheric chamber in a hospital outpatient clinic and is staged over several weeks.

____ 1. Antibiotic therapy may be used to help control possible post-operative infection. For some patients, such therapy may cause allergic responses or have undesirable side

____ 2. Despite all precautions, including HBO pre-treatment, there may be delayed healing, osteoradionecrosis, loss of bone and soft tissues, pathologic fracture of the jaw, oral- cutaneous fistula, or other significant complications.

____ 3. If osteoradionecrosis should occur, treatment may be prolonged and difficult, involving ongoing intensive therapy including hospitalization, further hyperbaric oxygen therapy, long-term antibiotics, and debridement to remove non-vital bone. Reconstructive surgery may be required, including bone grafting, metal plates and screws, and/or skin flaps and grafts.

____ 4. Even if there are no immediate complications from the proposed dental treatment, an irradiated area is always subject to spontaneous breakdown and infection due to the precarious condition of the bony blood supply. Even minimal trauma from a toothbrush, chewing hard food, or denture sores may trigger a complication.

____ 5. Long-term post-operative monitoring may be required and cooperation in keeping scheduled appointments is important. Radiation brings about side effects such as decreased salivary flow, "radiation caries", and other problems not ordinarily seen with patients who have not received cancer treatment. Regular and frequent dental check-ups with your dentist are important to monitor such issues and prevent further breakdown in oral health.

____ 6. I have read the above paragraphs and understand the possible risks of undergoing my planned dental treatment. I understand and agree to the following treatment plan:



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____ 7. I understand the importance of my health history and affirm that I have given any and all information that may impact my care. I understand that failure to give true health information may adversely affect my care and lead to unwanted complications.

____ 8. I realize that, despite all precautions that may be taken to avoid complications, there can be no guarantee as to the result of the proposed treatment.

____ 9. I request and authorize medical/dental services for myself, including oral surgery. I fully understand the contemplated procedure, surgery, or treatment conditions that may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modifications in design, materials, or care, if it is felt this is for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated I further authorize and direct my doctor, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the procedure.

____ 10. I certify that I speak, read and write English and have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my initials or signature.

Patient's (or Legal Guardian's) Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____