

**CONSENT FOR ARTHROSCOPY OF THE
TEMPOROMANDIBULAR JOINT(S) (TMJ)**

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You have the right to be informed about your condition and the recommended treatment plan to be used so that you may make an informed decision as to whether or not to undergo the procedure. This disclosure of potential risks is not meant to alarm you, but is rather an effort to properly inform you so that you may give knowledgeable consent.

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

PURPOSE:

___1. Dr. _____ has explained to me about the pathology (disease) that exists in my jaw joint (TMJ, temporomandibular joint). I understand that this procedure is somewhat exploratory in nature and is being done to diagnose my jaw problem and may help to alleviate symptoms of pain and limitation of my jaw joint(s).

___2. The arthroscopy procedure has been described to me and I understand that it is performed through a small skin incision or puncture just in front of my ear. A small telescope-like instrument is inserted through this incision directly into the jaw joint to inspect the inside of the joint. Occasionally a second skin incision is required for manipulating a second instrument or to facilitate joint washing (lavage). If possible, fibrous adhesions (scars within the joint) may be removed (lysis), which may be sufficient treatment to alleviate some of my joint symptoms.

___3. I further understand that a more involved procedure may still be required, depending upon the findings during this surgery. If such open joint surgery is required, I realize it may be done at the same time as this arthroscopy. If I desire an open joint surgery, I understand I will be asked to sign a separate consent form for that procedure.

ALTERNATIVES TO ARTHROSCOPIC SURGERY:

___1. I have been informed of alternative methods of treatment for my disorder including:

___2. I have been made aware that certain side effects and complications may result from arthroscopic surgery and these may include, but are not limited to, the following:

___A. Temporary or permanent facial muscle weakness or paralysis resulting from injury to motor nerves in the area during surgery. The most common problem is an inability to wrinkle the brow, raise the eyebrow or gain tight closure of the eyelids.

___B. Numbness (temporary or permanent) of certain areas of skin in the area of the joint and sometimes in more remote areas of the face or scalp.

___C. During arthroscopy, bleeding may be encountered within or around the joint that cannot be adequately controlled through the scope instrument and may require immediate open surgery.

___D. Due to the fact that arthroscopy is performed very close to the ear canal, ear problems may result, including inflammation of the canal, middle or inner ear infections, dizziness or loss of balance, and perforation of the ear drum with temporary or permanent hearing loss.

___E. The possibility of instrument failure or separation that may require open surgery.

___F. Facial scarring from skin incisions.

___G. Possibility of damage to the jaw joint surface during arthroscopic examination and surgery. This is usually of a reversible nature but could permanently affect joint function.

___H. Unsuccessful attempts to enter the joint or inability to accomplish the desired procedure because of limited joint mobility or other anatomic restriction.

___I. Worsening of present TMJ symptoms that may require repeat arthroscopy or open joint surgery.

___J. Changes in bite after arthroscopy that may affect chewing function. In addition there may be limited mouth opening. These are expected to be temporary, but may be permanent.

___K. Postoperative infection requiring additional treatment.

___L. Adverse or allergic reactions (previously unknown) to any of the medications used in the procedure.

___M. Excessive swelling of the facial area that may take several days to resolve.

___N. Complications associated with the use of medications and/or other pharmaceutical agents.

___3. I understand that all of my current symptoms may not change after this procedure and that future additional treatments may require [physical therapy, splint therapy, restorative dentistry, orthodontics (braces), or further reconstruction of the temporomandibular joint, including implant devices or bone grafting.

___4. I agree to avoid the use of drugs, medicines and natural or homeopathic remedies not prescribed or approved by this office, and to avoid contact sports, water sports and strenuous physical activity for six weeks following arthroscopy.

___5. I agree to comply fully with physical therapy or other rehabilitative procedures prescribed by my surgeon.

___6. I agree to fully comply with the recommendations of Dr. _____ realizing that lack of cooperation may result in a less than optimal result. I understand that there can be no warranty or guarantee as to the result and/or cure, and that my condition may return or become worse after arthroscopy

___7. I have had the opportunity to discuss my past medical and dental history with the doctor, including medical or health problems, drug and alcohol use and any other information that might affect this surgery.

___8. I have been given the opportunity to obtain a second opinion from a qualified professional regarding this proposed procedure.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ THIS ENTIRE CONSENT FORM, THAT I UNDERSTAND ENGLISH AND FULLY COMPREHEND THE NATURE OF THIS PLANNED OPERATION, AND THAT ALL BLANKS WERE PROPERLY FILLED IN BEFORE I SIGNED.

Patient's or Legal Guardian's Signature

Date

Doctor's Signature

Date

Witness' Signature

Date