INFORMATION & INFORMED CONSENT · SURGICAL DENTISTRY

CD-C20

Apicoectomy (Root-End Surgery)

Please read this form carefully before your treatment. It explains what is involved, the benefits, the risks and your options. Ask your dentist about anything you do not understand. You do not have to sign until you are ready.

PATIENT DETAILS

PATIENT NAME

DATE OF BIRTH

TOOTH

TREATING DENTIST

CLINIC

01 About the treatment

An apicoectomy treats persistent infection at the tip of a root-filled tooth when root canal re-treatment is not possible or has not worked. The gum is lifted, the infected tissue and the last few millimetres of the root tip are removed, the root end is sealed with a filling, and the gum is stitched back.

EXPECTED BENEFITS

- Can save a tooth that would otherwise need extraction
- Removes chronic infection at the root tip

ALTERNATIVES

- No treatment (infection will continue)
- Root canal re-treatment
- Extraction and replacement with an implant, bridge or denture
- Referral to an endodontist

02 Risks and possible complications

All dental treatment carries some risk. Most complications are uncommon and manageable, but you should know about them before deciding. Risks specific to you, including those relating to your medical history, have been discussed with you.

- **Local anaesthetic.** Numbness usually wears off within 2 to 5 hours. Bruising or tenderness at the injection site, temporary jaw stiffness or a racing heartbeat can occur. Rarely, an injection touches a nerve and causes numbness or tingling that lasts weeks or longer, or an allergic reaction occurs.
- **Pain, swelling and bruising** are expected and usually peak 2 to 3 days after surgery, then settle over 7 to 10 days.
- **Bleeding.** Oozing for up to 24 hours is normal. Prolonged bleeding is uncommon and is more likely if you take blood thinners.
- **Infection** may require antibiotics, drainage or further treatment.
- **Limited mouth opening and jaw stiffness** for several days.
- **Damage to neighbouring teeth, fillings or crowns** during surgery.

- **Nerve injury (lower jaw).** Nerves supplying the lower lip, chin, tongue and teeth lie close to the lower back teeth. Bruising or injury can cause numbness, tingling or altered taste. This is usually temporary but in rare cases is permanent.
- **Sinus involvement (upper jaw).** Upper back teeth lie close to the maxillary sinus. An opening between the mouth and sinus can occur, which may need further treatment to close. Sinus infection or congestion can also occur.
- **Failure to heal.** A proportion of teeth do not heal and may later need extraction.
- **Gum recession or scarring** at the incision line, which may affect appearance at the front of the mouth.
- **Loosening** of the tooth if a large amount of bone has been lost.
- **Fracture** of the root may be found during surgery, in which case extraction is recommended.

03 Your acknowledgement

Tick each box to confirm you understand and agree.

- [ ] I have read this form, or it has been read to me, and I understand it.
- [ ] The dentist has explained the proposed treatment, why it is recommended, the expected benefits, the material risks and the reasonable alternatives, including no treatment.
- [ ] I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.
- [ ] I understand that dentistry is not an exact science and that no guarantee has been given about the outcome or how long treatment will last.
- [ ] I have given the dentist a complete and accurate medical history, including medicines, supplements, allergies and pregnancy (if applicable), and I will tell the clinic of any changes.
- [ ] I understand that unforeseen findings during treatment may require a change in plan, and that the dentist will discuss this with me where practical.
- [ ] I have received a written estimate of fees. I understand that fees may change if the treatment plan changes, and that health fund rebates are my responsibility to confirm.
- [ ] I consent to clinical photographs, X-rays and scans being taken and kept in my record. These will not be used for any other purpose without my separate written consent.
- [ ] I understand that I may withdraw my consent at any time before or during treatment.

04 Financial consent

ESTIMATED FEE ($) _____ ITEM NUMBERS / QUOTE REFERENCE _____

05 Consent

I, the undersigned, consent to **Apicoectomy (Root-End Surgery)** as described above, and to the administration of any local anaesthetic or other medicines needed for this treatment.

Patient (or parent / guardian / substitute decision-maker)

FULL NAME _____ SIGNATURE _____ DATE _____

Dentist

I have explained the treatment, risks, benefits and alternatives, and answered the patient's questions.

NAME _____ SIGNATURE _____ DATE _____

Interpreter (if used)

NAME / LANGUAGE _____ SIGNATURE _____ DATE _____