**Süleyman Demirel University Faculty of Dentistry**

**Consent Form for Patients Undergoing Orthognathic Surgery:**

**File Number:**

**Patient Name and Surname:**

I have been thoroughly informed about the dentofacial disorder (a condition involving the teeth and jaws, affecting occlusion and appearance) by the dentist who will examine me and perform my surgery/surgeries, namely, _____. I am aware that a combination of orthodontic and surgical treatments is applied for the treatment of the dentofacial disorder I have. I am aware that, just like before the surgery, I will undergo orthodontic treatment after the surgery, and the duration of this treatment will be determined by my doctors. I am aware that in cases where my issue cannot be resolved with a single surgery, I may need to undertake consecutive surgeries.

I am aware that the surgeries will be conducted under general anesthesia.

I am aware that, as part of the preparation for general anesthesia before these surgeries, I will undergo various assessments such as blood tests, a lung X-ray, and EKG (Electrocardiography). I am aware that, if deemed necessary by the doctor administering the anesthesia, I may be referred to other medical specialties before or after the surgery.

I am aware that, if necessary due to potential postoperative bleeding, I may need to procure blood of my own blood type, in the quantity determined by my doctor, before entering surgery, as instructed by my doctor, _____.

I know that if the procured blood is not needed for the surgery, it will be returned to me.

I am aware that, even if everything goes well from a surgical perspective during the surgeries, I may encounter some undesired outcomes related to anesthesia.

I am aware that during these surgeries, jawbone incisions will be made, and after giving new positions to the cut bones, they will be stabilized to each other with plates and/or screws.

I am aware that I will need to pay a certain fee for the blood I procured before the surgery, as well as for the plates and/or screws that will be used during the operation and for the surgery and anesthesia. Although a portion of the expenses may be covered by the social security institution, I understand that any remaining amounts will be my responsibility to pay. I know that, regardless of the success of the surgery, certain undesired complications, known as complications, can appear both during and after the operation.

I am aware that during the surgery, there may be excessive bleeding, tensions, tears, nerve damage, and injuries to the lips, nose, or palate that may occur while performing tissues stretching. I am aware that unwanted fractures in the jawbones may occur during the incisions made on the jawbones, and as a result of these fractures, the planned corrections in the bones may become impossible. Therefore, I understand and accept that I may need to undergo repeat surgeries in subsequent periods.

I am aware that after the surgery, depending on the involvement of both upper and lower jaws (sometimes knowing that both may be operated on simultaneously), there may be consequences such as bleeding in the suture areas, infection in soft tissues or bones, excessive swelling on my face, palate perforation, sinusitis, nasal inflammation, nasal congestion, difficulty or inability to breathe through the nose. I understand that there could be complications such as suture dehiscence, tissue necrosis, and appearance alterations due to issues in either soft or hard tissues, including asymmetries. Additionally, I am aware that if these complications do not respond to other treatments, repeated surgeries may be necessary. I know that in cases where working through the inside of the mouth is not feasible, there may be stitches on the skin, leading to possible scars. While the surgery, there is a risk of nerve damage, with a 5-10% chance of complete severance, potentially resulting in loss of sensation or complete numbness in my lower lip, tongue, or palate. I understand that if numbness persists without responding to medication or laser treatment, I may need to undergo surgery again, and I acknowledge and accept this.

I am aware that after the surgery, my mouth will be closed for a specific duration using elastics attached to orthodontic wires on my teeth. I realize that I may experience some discomfort in speech and eating during this time.

I know that following the surgery, it is crucial to adhere to the recommended dietary guidelines, take prescribed medications regularly, and maintain proper oral hygiene and dressings. I accept to conform to all recommendations regarding nutrition, medication use, dressings, and the recovery period.

I know that individuals with my condition may require psychological support, and I recognize and accept this.

As a patient with dentofacial deformity that requires lengthy treatment and may involve repeated surgeries, I hereby grant all authority regarding surgeries to ……. . And being fully aware of all the above explanations, I willingly accept ..... to perform my surgeries, understanding all potential complications that may arise.

**Special circumstances:** Süleyman Demirel University Department of Oral and Maxillofacial Surgery Clinic doctors can be reached by phone at 0246 2113348 or by visiting the clinic in person.

I have been informed about the Implementation Communiqué published by the Social Security Institution (SGK) regarding the relevant treatments. I am aware that invoices related to items for which the SGK does not make payments for the materials used during the stages of the treatment need to be paid by me.

My identity information will be kept confidential, and I have been informed that my medical history and radiological images, photographs, and test results (pathology report, laboratory results, etc.) may be used for diagnostic, scientific, educational, or research purposes. The document we want you to read and understand is not meant to scare you or keep you away from medical procedures. It is prepared to inform you, determine whether you consent to these procedures, and obtain your approval. This consent form consists of 2 pages and has been prepared in duplicate in accordance with Article 70 of Law No. 1219 and Article 26 of Turkish Penal Code No. 5237. One copy has been provided to the patient/legal representative of the patient.

I HAVE BEEN INFORMED ABOUT THE TREATMENT RELATED TO MY ILLNESS, AND I HAVE READ AND UNDERSTOOD THIS FORM. I ACCEPT THE TREATMENT.

Note: this statement will be written by the patient/relative in their own handwriting below.

…….

| PATIENT/RELATIVE | THE DOCTOR PROVIDING THE INFORMATION: |
|---|---|
| NAME: ..... | NAME:…… |
| DATE: ..... | DATE:…….. |
| TIME: ..... | TIME:……. |
| SIGNATURE:……. | SIGNATURE:…….. |