



HD.RB.14	YT:14.01.2015	EV.NO:01	REV.T: 18.04.2022	S.NO: 1/1
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Legal Representative: The purpose of this form is to inform you about the treatment/procedure to be performed and to obtain your consent. Please read each item carefully. While this information form describes the emergency dental trauma treatment performed in clinics, it also aims to provide information about possible risks that may arise due to the procedure, treatment methods, expected benefits from the treatment, situations that may arise if treatment is not received, and the patient's responsibilities. After reading this form, you can ask your doctor any other questions you may have about the procedure. In order for the procedure to be performed, this consent document must be read and signed by the patient himself. If the patient cannot give consent due to age or medical reasons, it is read, filled out and signed by his/her Attorney/Legal Representative.

55	54	53	32	51	61	62	63	64	65						
<b>18</b>	<b>17</b>	<b>15</b>	<b>13</b>	<b>14</b>	<b>13</b>	<b>12</b>	<b>11</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>	<b>25</b>	<b>27</b>	<b>28</b>
<b>48</b>	<b>47</b>	<b>46</b>	<b>45</b>	<b>44</b>	<b>43</b>	<b>42</b>	<b>41</b>	<b>31</b>	<b>32</b>	<b>33</b>	<b>34</b>	<b>35</b>	<b>36</b>	<b>37</b>	<b>38</b>
85	84	83	82	81	71	72	73	74	75						

**Emergency Dental Trauma Treatments**

As a result of clinical and radiographic examination of teeth exposed to trauma, broken teeth are restored temporarily or permanently. If there are broken tooth pieces, the tooth can be restored with its own parts, loose or displaced teeth can be fixed to other teeth with the help of wire and/or adhesive resin material for a period of 2 weeks to 4 months, and displaced teeth can be replaced if appropriate conditions are provided. If the traumatized teeth have lost their vitality at the time of initial application or subsequent control sessions, root canal treatment may be performed or the teeth may need to be extracted. Before and after treatment photographs can be taken to monitor the patient's oral and dental condition. The physician may recommend renewal of the tetanus vaccine when deemed necessary. What is expected from the treatment: It is aimed to preserve the vitality of the relevant teeth, to fix the loose teeth and keep them in place, and to relieve pain if there is any. The success of the treatment to be applied; Late visits to the doctor, the way the tooth remains outside the mouth and the way it is brought in are directly affected by good or bad oral hygiene.

**Treatment time: Approximately 30-60 min.**

**If the recommended treatment is not applied:** The destruction of the tooth and surrounding tissues continues, and tooth extraction may become necessary. Possible risks: Long-term follow-up is important in trauma cases, and regular attendance at control sessions in line with the doctor's recommendation in order to prevent problems that may occur in the future affects the results of the treatment. It may be necessary to make changes in the treatments applied for reasons depending on the healing potential of the teeth and surrounding tissues, the time of admission to the clinic, the severity of the trauma and the patient's oral care. If problems such as pain, swelling, or color change occur in the tooth, it may be necessary to apply to the clinic before the control session. When the tooth and surrounding tissues do not respond positively to treatment, tooth extraction may be necessary.

**Things to consider after the treatment:** You can eat after the anesthesia effect (drowsiness) wears off. The patient should eat a soft diet for 1 week and should not consume hard foods with traumatized teeth. The patient should regularly brush all his teeth, including the traumatized teeth, with a soft brush and pay attention to keeping the trauma area clean. Antibiotics, painkillers and mouthwashes given to the patient should be used regularly as recommended by the physician.

A detailed examination of my entire mouth was performed. In addition, in the relevant sections, physicians explained what oral and dental disease is, why treatment is needed, the risks involved, problems that may occur, alternative methods, changes that may occur after treatment, the possibility of success and situations that may occur during the healing process.

**Special Cases:** You can reach the doctors of Süleyman Demirel University Faculty of Dentistry Department of Endodontics by calling 0246 211 3351 or by calling.

**APPROVAL**

During the diagnosis and treatment of the dentist;

Consultation may be requested from other physicians and they can participate in the treatment process,

Intern dentists will participate in diagnosis and treatment and will work under the supervision of assistants and faculty members,

Oral and Maxillofacial Radiology doctors, intern dentists, dental technicians and , can be used for educational or research purposes, local anesthesia can be applied as a part of these procedures during the diagnosis method, intervention or treatment, attending the appointments without interruption and following the doctor's recommendations and practices regarding the treatment can directly affect the treatment results,

It was explained to me.

Dear Patient, To have information about your health condition and the benefits/harms, risks and alternatives of the procedures for the diagnosis or treatment recommended for you; accept or partially/completely reject treatment; You have the right to stop the transactions at any stage! This document, which we want you to read and understand, has been prepared not to scare you or keep you away from medical practices, but to inform you, determine whether you consent to these practices, and obtain your consent. This consent form consists of 1 page and has been prepared in 2 copies in accordance with Article 70 of Law No. 1219 and Article 26 of the Turkish Penal Code No. 5237, and one copy has been given to the patient/legal representative of the patient.

THE TREATMENT FOR MY DISEASE WAS EXPLAINED TO ME AND I HAVE READ AND UNDERSTOOD THIS FORM. I ACCEPT THE TREATMENT. (Note: This statement will be written below in the patient's/relative's OWN HANDWRITING.)

.....  
PATIENT/RELATIVE/GUARDIAN:  
DATE:  
TIME:  
SIGNATURE/STAMP:

.....  
NAME AND SURNAME OF THE DOCTOR  
WHO PROVIDED THE INFORMATION:  
DATE:  
TIME:  
SIGNATURE/STAMP: