SULEYMAN DEMIREL UNIVERSITY
FACULTY OF DENTISTRY

DEPARTMENT OF PEDIATRIC DENTISTRY
FISSURE SEALANT TREATMENT
INFORMED CONSENT

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Dear patient/parent/guardian,

- Please read this document carefully.
- You have the right to be informed about your medical condition and the treatment and procedures recommended for the treatment of your disease.
- The purpose of these explanations is to inform you about your oral and dental health and to ensure your participation in the treatment process.
- If you have any questions other than those mentioned here, it is our responsibility to answer them. We are here to help you.
- After you have been informed about the benefits and possible risks of diagnostic procedures, medical and surgical treatments, it is your decision to consent to the procedure.
- If you wish, all information and documents related to your health can be given to you or a relative of your choice.
- If you have literacy problems or if you would like another person of your choice to participate in the process of consenting to the procedures to be carried out on you, you can allow the person you designate to participate as a witness in the interview.
- You can refuse to be informed except in cases of legal and medical necessity.
- You have the right to withdraw your consent at any time. This will not hinder your further treatment in any way. However, legally, this right is subject to the condition that "there is no medical inconvenience". When this happens, a Withdrawal of Informed Consent Form will be drawn up and attached to the back of this document.
- You must inform your physician about existing systemic diseases, allergies, medications and general health status. You are responsible for any concealment or failure to disclose any information.
- In order not to disrupt our health institutions appointment system and treatment program, please take care to be faithful to your appointments and to arrive on time. If it is not possible for you to come, please cancel your appointment at least 24 hours in advance. If you do not arrive at the appointment time, your appointment may be postponed to another day depending on the availability of the clinic.
- Information and consent processes for patients who do not have the ability to make decisions regarding diagnosis and treatment, such as unconscious patients, pediatric patients, mentally disabled patients, and patients requiring emergency intervention will be carried out with you.
- You will be responsible for informing and obtaining the consent of disabled persons whose parents or guardians you are, in accordance with their disability status.
- If necessary, you can reach the clinic where you received treatment/procedures during office hours (8.30-16.30) by calling 0246 211 33 49 for medical assistance.

1. INFORMATION

THE TOOTH TO BE TREATED	DIAGNOSIS	TREATMENT PLANNING
55 54 53 52 51 | 61 62 63 64 65 18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28 48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38 85 84 83 82 81 | 71 72 73 74 75		

In fissure sealant treatment; It is aimed to prevent the onset or deepening of tooth decay by covering the pits and grooves on the chewing surface of the molars with a tooth-colored or transparent flowable filling material.

Content of the treatment:

Fissure sealant application: The depth of the grooves on the chewing surfaces of the teeth varies from tooth to tooth. Over time, discoloration or initial caries lesions may appear in these grooves due to the accumulation of food residues and bacteria. For the purpose of the procedure, sometimes without any abrasion on the tooth surface or in cases where discoloration and caries onset are detected, the discolored and caries-onset tooth tissue is removed with the help of a low-speed handpiece and/or a water-cooled high-speed handpiece. In the meantime, the treatment planning may change depending on the amount of tissue loss that will occur depending on the depth of decay in the tooth. Your dentist will give you the necessary information. If the treatment plan proceeds as planned, the tooth is restored with tooth-colored or transparent flowable filling materials after removal of the discolored and decayed tissue.

Expected benefits of the transaction: To prevent the formation of caries in the grooves structurally located on the chewing surfaces of the teeth and to protect the teeth. **Consequences if the procedure is not followed:** The decay can progress and lead to the need for filling or root canal treatment and even tooth loss. **Alternative to the transaction:** There is no alternative to fissure sealant treatment. **Complications of the procedure**: If the child moves during and after the removal of the decayed tissue and filling, injury to the tongue, lips and cheeks, bleeding in the gums, the filling falling out and allergic reactions due to the filling material may develop due to working with sharp instruments. **Estimated duration of the process:** It's 20 minutes.

Points to be considered before and after the procedure and problems that may occur if not taken into consideration: Providing oral care before the procedure is important for the success of the fissure sealant to be applied. During the procedure, if the child's compliance with the physician is impaired, the fissure sealant cannot be placed properly and may fall off in a short time. In cases where adequate oral care is not provided after the procedure, caries may reoccur on the teeth where fissure sealant has been applied. If hard foods are eaten, the fissure sealants may break and these areas may become more prone to food debris adhesion, thus increasing the risk of tooth decay. Therefore, fissure sealants need to be monitored at regular intervals.

Date:

The physician responsible for the patient	Faculty member responsible for the patient
Name-Surname:	Name-Surname:
Signature:	Signature:

2. CONSENT (PERMISSION, ASSENT)

I/the undersigned guardian of the patient ……,
Dentist..... I have been informed about the diagnosis and treatment planning, alternative treatments, results, unwanted side effects, I have been informed about, understood and accepted the treatment to be applied. I have been informed about the possible risks that may arise if the treatment is not applied, cost calculations according to alternative treatments, consultation from other physicians may be requested if deemed necessary, I have been informed about, understood and accepted. I was informed that treatment services are provided by appointment in the clinic of the Department of Pedodontics for patients other than emergencies (fractures and injuries in the mouth, teeth, jaw area, facial swelling), patients requiring special care (disabled), patients with life-threatening systemic diseases, as determined by the first examination physician. All questions I wondered about the treatment of my treatment/guardian were answered. It was explained to me that attending the appointments without fail and following the recommendations and practices of the physician regarding the treatment can directly affect the results of the treatment. I was explained, understood and accepted that the success of the treatments to be performed depends on me, that I should follow the oral cleaning and recommendations at home, that I should fulfill the recommendations regarding harmful habits that should be abandoned, and that I should use the medications in the prescriptions to be prescribed in the doses and durations appropriate to the recipe. I was explained, understood and accepted that the treatments to be applied aim to protect oral and dental health, that medical services will be carried out with care, but that the result cannot be guaranteed in medical procedures. I was informed in detail about patient rights and responsibilities, physician rights and obligations. I am aware that Süleyman Demirel University Faculty of Dentistry is an educational institution and that trainee dentists and specialty students work here. I give permission to Süleyman Demirel University Faculty of Dentistry faculty members, dentists and trainee dentists to perform oral dental examination, diagnosis and treatment of the individual whose parent/guardian I am. I …… (Write "I give" or "I do not give" in your handwriting.) permission to take photographs and use my medical records during the intervention/treatment to be applied to me, provided that the identity information is kept confidential and used only for education and research purposes.

(*) Legal Representative: For minors and/or incompetent persons, the informed consent of the parent or guardian is required.

Dear Patient, You have the right to be informed about your health condition and the benefits/harms, risks and alternatives of the proposed diagnostic or therapeutic procedures; to accept or partially/completely reject the treatment; and to stop the procedures at any stage! This document, which we want you to read and understand, has been prepared not to scare you or to keep you away from medical practices, but to inform you, to determine whether you consent to these practices and to obtain your consent. This consent form consists of 2 pages and has been prepared in 2 copies in accordance with Article 70 of the Law No. 1219 and Article 26 of the Turkish Criminal Law (No. 5237), and one copy has been given to the patient/patient's legal representative.

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

…….

PATIENT'S/RELATIVE'S/GUARDIAN'S	THE PHYSICIAN PROVIDING THE INFORMATION
NAME SURNAME :……..	NAME SURNAME :…….
DATE:……	DATE:……..
TİME:……..	TİME:……..
SIGNATURE	SIGNATURE/STAMP