

SÜLEYMAN DEMİREL ÜNİVERSİTESİ



HD.RB.52	YT:14.01.2015	REV.NO:01	REV.T: 18.04.2022	S.NO: 1/1

File No:

BARCODE

Patient Name and Surname:

Dear Patient / Legal representative;

The purpose of this CONSENT form; It is to ensure that you are informed in writing and verbally about the possible side effects that may be encountered during all procedures/applications to be applied for your treatment, to document that you accept the examination and treatment knowing these, and to obtain your approval and sign it.

• After learning the benefits and possible risks of medical treatment It is still up to you to consent to the procedure to be performed or not.

• Before starting the treatment, it is important to share with your physician any systemic, infectious diseases or allergies you have had;

• The success rate of all treatments is very high. It should be known that although it is not guaranteed, the treated teeth may need to be extracted, and the treatment and the disease may recur in the future.

• If you want to exercise your right to refuse or terminate the treatment, please inform your physician.

• To reach medical assistance when necessary, you can call 0246 211 33 47 and reach the clinic where you had the treatment/procedure during working hours (8.30-16.30).

• This form is prepared in two copies, one copy is given to the patient. You have the right to withdraw your consent if the transaction has not been initiated even after your approval.

• For your comments, suggestions, thanks and complaints about our services; You can apply to the patient rights unit, send them to the wish-complaint and suggestion boxes at our Center, send them to us from the Write to Us section on our website.

Diagnosis /Pre-Diagnosis:				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			

PERIODONTAL ABSCESS

Definition of the Procedure; Periodontal abscess can be acute or chronic. In the acute case, severe pain, swelling, lymphadenopathy, fever and malaise are observed. In this case, treatment is started by giving antibiotics to the patient. After the use of antibiotics, the abscess is drained. For this, local anesthesia is applied to the area and subgingival curettage is performed. Flap surgery is performed when necessary. If the abscess is chronic, antibiotic treatment is often not required.

By whom and where the procedure will be performed: The procedure will be performed by the faculty members of the Department of Periodontology and dentists in postgraduate education (doctorate or specialty) and in the Periodontology Clinic.

Expected Benefits from the Procedure; First of all, it is aimed to eliminate the patient's complaints such as pain and swelling. It is aimed to recover the tissues lost as a result of abscess.

Possible Side Effects, Risks and Complications; Local anesthesia may be required during treatment. Complications due to local anesthesia may occur.

Estimated Duration of the Procedure; Depending on the age and compliance of the patient, the procedure time may vary between 5-10 minutes. It is done with hand tools and/or ultrasonic tools, and the abscess inflammation is drained. For this, local anesthesia is applied to the area. It may take 1-2 sessions. Problems that may be encountered if the procedure is not performed: As a result of bone loss resulting from the progression of the periodontal abscess into deeper tissues, increased tooth mobility, decreased chewing function and tooth loss may occur in the future.

Critical Lifestyle Recommendations for Your Health; After the treatment, there may be hot-cold sensitivity and mild pain, and mild inflammation and bleeding on the first day. Painkillers can be used to eliminate pain. Antibiotics and mouthwashes should be used regularly if recommended by the physician. At the same time, tooth brushing and flossing should be continued.

Alternative: There is no alternative to this treatment. If the disease is left untreated, pain, swelling, lymph swelling, fever and fatigue may occur and may impair general health. Eventually the teeth become loose and may need to be extracted.

APPROVAL

During the dentist's diagnosis and treatment;

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

Oral and Maxillofacial Radiology doctors, trainee dentists, dental technicians and x-ray technicians can take part in my filming,

My history and anamnesis information can be kept confidential while my identity information is kept confidential. My radiological images, photographs, examination results (pathology report, laboratory results, etc.) can be used for diagnostic, scientific, educational or research purposes,

Local anesthesia may be applied as a part of these procedures during the diagnosis method, intervention or treatment, and It was explained to me that following the doctor's recommendations and practices regarding treatment can directly affect the treatment results.

I was informed about the Implementation Communiqué published by the Social Security Institution (SGK) regarding the relevant treatments. I have been informed that the invoices for the items that SSI does not pay for the materials to be used during the stages of the treatment must be paid by me.

I know that I have the right to refuse or terminate treatment. I find all verbal and written information sufficient. I have read, understood and approved the "Informed Consent Form" for all examinations and treatments. to be; 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 2 pages and has been Patients Abbreviated Signature



HD.KD.52 11.14.01.2015 KEY.MO.01 KEY.11.10.04.2022 5.100.172	HD.RB.52	YT:14.01.2015	REV.NO:01	REV.T: 18.04.2022	S.NO: 1/2
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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.

I HAVE BEEN INFORMED ABOUT THE TREATMENT RELATED TO UNDERSTOOD THIS FORM. I ACCEPT THE TREATMENT	,
(Note: This statement will be printed below in the patient's/family member's	,
THE NAME AND SURNAME OF THE PATIENT/PATIENT'S RELATIVE/ PATIENT'S GUARDIAN:	THE NAME AND SURNAME OF THE PHYSICIAN PROVIDING THE INFORMATION.
DATE:	DATE:
TIME:	TIME:
SIGNATURE	SIGNATURE