NORTHEAST
Dental Group

# Northeast Dental Group

'A Dental Destination Location'

7770 Frontage Rd #7341
Cicero, NY 13039

## CONSENT FOR DENTAL TREATMENT IN IRRADIATED AREAS

Patient's Name Date

**Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.**

Since I have been treated previously for cancer with radiation (x-ray therapy to eradicate cancer cells), I should know that there is a significant risk of future complications when dental treatment is planned within those areas. Therapeutic radiation to jaw and facial regions may adversely affect the blood supply to bone, and reduce its ordinary excellent healing capacity. This risk is increased after surgery, especially from extraction; implant placement or other "invasive" procedures that might cause even mild trauma to bone. Osteoradionecrosis may result. This is a smoldering, long-term, destructive process in the jawbone that is often very difficult to eliminate.

If the area of proposed treatment is within the area previously irradiated, it may be advisable or necessary for me to undergo hyperbaric oxygen therapy (HBO) before any invasive procedure. HBO is known to improve blood supply and oxygenation in bone and reduce the risk of post-operative complications – but it is not a guarantee. HBO is performed in a special atmospheric chamber in a hospital outpatient clinic and is staged over several weeks.

____ 1. Antibiotic therapy may be used to help control possible post-operative infection. For some patients, such therapy may cause allergic responses or have undesirable side effects such as gastric discomfort, diarrhea, colitis, etc.

____ 2. Despite all precautions, including HBO pre-treatment, there may be delayed healing, osteoradionecrosis, loss of bony and soft tissues, pathologic fracture of the jaw, oral-cutaneous fistula, or other significant complications.

____ 3. If osteoradionecrosis should occur, treatment may be prolonged and difficult, involving ongoing intensive therapy including hospitalization, further hyperbaric oxygen therapy, long-term antibiotics, and debridement to remove non-vital bone. Reconstructive surgery may be required, including bone grafting, metal plates and screws, and/or skin flaps and grafts.

____ 4. Even if there are no immediate complications from the proposed dental treatment, an irradiated area is always subject to spontaneous breakdown and infection due to the precarious condition of the bony blood supply. Even minimal trauma from a toothbrush, chewing hard food, or denture sores may trigger a complication.

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## CONSENT FOR DENTAL TREATMENT IN IRRADIATED AREAS CONT…

____ 5. Long-term post-operative monitoring may be required and my cooperation in keeping scheduled appointments is important. Radiation brings about side effects such as decreased salivary flow, "radiation caries", and other problems not ordinarily seen with patients who have not received cancer treatment. Regular and frequent dental check-ups with my dentist are important to monitor such issues and prevent further breakdown in oral health.

____ 6. I have read the above paragraphs and understand the possible risks of undergoing my planned dental treatment. I understand and agree to the following treatment plan:

_____

_____

____ 7. I understand the importance of my health history and affirm that I have given any and all information that may impact my care. This includes the total amount of radiation I received during cancer therapy, the exact region(s) where it was applied, and the names of my cancer therapists. I understand that failure to give true health information may adversely affect my care and lead to unwanted complications.

____ 8. I realize that, despite all precautions that may be taken to avoid complications, there can be no guarantee as to the result of the proposed treatment.

### CONSENT

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to surgery.
I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date