

**Consent form for Extractions**

**Name of procedure or course of treatment:**

Extractions under local anaesthetic. Teeth to be extracted are as follows;

**Reason for extraction/ diagnosis:**

**Intended benefits of treatment:** To stop or prevent pain, remove and prevent spread of infection, restore function.

**Serious or frequently occurring risks**

**During procedure:**

- Inability to gain numbness of the tooth, fracture of tooth/root, bleeding, accidental damage to adjacent teeth.
- If extraction is complicated, then the tooth may need to be surgically removed. This involves making a cut in the gum, bone removal and stitches.
- If the tooth is unable to be extracted, then you may have to be referred to a specialist/rearrange for another appointment.
- For upper teeth only; possible communication with the maxillary sinus. You may require antibiotic cover, specialist referral and treatment if deemed necessary.

**After procedure:**

- Bleeding, swelling, pain, bruising, limited mouth opening and infection (dry socket increased risk if smoker or medically compromised).
- For lower teeth: temporary (6-12 months)/permanent altered sensation or numbness of the tongue, lower teeth, lower lip and chin on the side of extraction.
- Temporary or permanent taste disturbance.

**Post extraction instructions have been given to patient:** YES/NO

**Gauze has been given to patient to take home encase post extraction bleeding occurs:** YES/NO

**Statement of Patient**

I agree to the procedure as described above. I understand the information given. I understand that any procedure in addition to those described on this form will only be carried out if is necessary to save my life or prevent serious harm to my health. I have been told about additional procedures which may become necessary during my treatment. I have been given the opportunity to ask questions and these questions have been discussed and answered by the clinician.

Patient Signature:

Date:

Clinicians Signature:

Date: