ERCIYES UNIVERSITY
FACULTY OF DENTISTRY
DEPARTMENT OF ORAL AND
MAXILLOFACIAL SURGERY

INFORMED CONSENT FORM
TEMPOROMANDIBULAR JOINT
ARTHROSCOPY

Patient Name-Surname:
Date of Birth:
File Number:
Gender:
Phone Number:
Diagnosis:
Treatment Options:

- □ ……
- □ ……
- □ Local Anesthesia □ Sedation □ General Anesthesia

Treatment-related risks:

- □ Postoperative pain and swelling
- □ Airway problems due to the spread of fluid administered into the joint
  Bleeding in or around the ear
- □ Ear infection, hearing problems, dizziness, or ringing in the ear
- □ Bleeding inside the joint
- □ Intracranial perforation
- □ Needle breakage inside the joint
- □ Inability to enter the joint with the needle or cannula
- □ Need for open surgical procedure due to instrument breakage
- □ Postoperative infection requiring additional treatment
- □ Disruption of dental occlusion
- □ Treatment failure, need for retreatment, or worsening of the current condition
- □ Paralysis of facial nerves or other disorders due to nerve damage
- □ Development of life-threatening conditions requiring emergency treatment due to administered medications and local anesthesia (heart problems, sinus arrhythmia, bradycardia)
- □ Skin lesions
- □ Other: .....

As Dr…… I have explained the procedure to the patient/his or her mother/father/guardian/representative. Specifically, I emphasized the following points. Additionally, I have outlined what the procedure entails, the benefits and risks of alternative treatment methods (including not undergoing treatment), and other conditions specific to the patient.

1. Doctor's Name-Surname: Signature:

Date:

2. Doctor's Name-Surname: Signature:

Date:

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Please read this form carefully. If your treatment has been pre-planned, you should have a copy of the front page that outlines the benefits and risks of the proposed treatment. If not, please obtain a copy now. If you have any other questions, please ask. You have the right to change your mind at any time before entering the surgery, even after signing this form.

1. I accept the form and understand the nature and course of the treatment described herein.
2. I acknowledge that I have provided all relevant information regarding my general health status and have been informed about potential issues that may arise as a result.
3. I agree to fully comply with the recommendations of my doctors and understand that failure to do so may result in the failure of my treatment.
4. I understand that tissues removed during the procedure or treatment (including blood) may be used for diagnosis and examination and will be appropriately stored or disposed of in accordance with appropriate ethical, legal, and professional standards.
5. I accept that tissues not necessary for my diagnosis and treatment may be used for educational and genetic research purposes.
6. I understand that all research has been approved by the ethical research committee and is guaranteed to comply with appropriate ethical, legal, and professional standards.
7. I understand that all research is conducted not by for-profit organizations or companies but by a university or hospital.
8. I consent to the taking of photographs for diagnostic and treatment purposes.
9. I consent to the use of photographs for educational purposes without identifying me.
10. I understand that there is no guarantee as to who will perform my treatment. I trust that whoever performs my treatment will have sufficient experience.
11. I understand that, if circumstances permit, I can discuss the details of anesthesia with the anesthesiologist before the procedure (for patients undergoing general or regional anesthesia only).
12. I understand that procedures other than those specified in this form may be performed solely to save my life or prevent serious harm to my health. I have been informed of the possibility of other procedures being performed during my treatment. Below, I have listed procedures that I do not wish to be performed without my consent.

Patient's/Parent's Name-Surname: Signature: Date:
……