Christine Taxin's

Links2Success

Linking Doctors to Success

Informed Consent Forms

Opioid Therapy for Chronic Pain: Sample Informed Consent
Informed Consent Cone Beam CT Scan
Oral Surgical Treatment in Patients who have received Oral Bisphosphonate Drugs

Opioid Therapy for Chronic Pain: Sample Informed Consent*

Please review the information listed here and put your initials next to each item when you have reviewed it with your provider and feel you understand and accept what each statement says.

_____My provider is prescribing opioid pain medications for the following conditions(s):

_____

_____When I take these medications, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

_____When I take these medications it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.

_____When I take these medications regularly, I will become physically dependent on them, meaning that my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

_____I may become addicted to these medications and require addiction treatment if I cannot control how I am using them, or if I continue to use them even though I am having bad or dangerous things happen because of the medications.

_____ Anyone can develop an addiction to opioid pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I have told my provider if I or anyone in my family has had any of these types of problems.

_____Taking too much of my pain medication, or mixing my pain medications with drugs, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.

_____I understand that taking certain medications such as buprenorphine (Suboxone®, Subutex®, naltrexone (ReVia®), nalbuphine (Nubain®), pentazocine (Talwin®), or butorphanol (Stadol®) will reverse the effects of my pain medicines and cause me to go into withdrawal.

_____It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.

_____I have discussed the possible risks and benefits of taking opioid medications for my condition with my provider and have discussed the possibility of other treatments that do not use opioid medications, including:

_____

_____These medications are being prescribed to me because other treatments have not controlled my pain well enough.

_____These medications are to be used to decrease my pain but they will not take away my pain completely.

_____These medications are to be used to help improve my ability to work, take care of myself and my family, and meet other goals that I have discussed with my provider, but if these medications do not help me meet those goals, they will be stopped.

_____**For Men**: Taking opioid pain medications chronically may cause low testosterone levels and affect sexual function.

_____**For Women**: It is my responsibility to tell my provider immediately if I think I am pregnant or if I am thinking about getting pregnant. If I become pregnant while taking these medications and continue to take the medicines during the pregnancy, the baby will be physically dependent on opioids at the time of birth and may require withdrawal treatment.

I have reviewed this form with my provider and have had the chance to ask any questions. I understand each of the statements written here and by signing give my consent for treatment of my pain condition with opioid medications.

_____	_____	_____
Patient signature	Patient name printed	Date
_____	_____	_____
Provider signature	Provider name printed	Date

*Adapted from the American Academy of Pain Medicine - www.painmed.org

Informed Consent Cone Beam CT Scan

1. A CBCT scan, also known as Cone Beam Computerized Tomography, is an x-ray technique that produces 3D images of your skull that allows visualization of internal bony structures in cross section rather than as overlapping images typically produced by conventional x-ray exams. CBCT scans are primarily used to visualize bony structures, such as teeth and your jaws, not soft tissue such as your tongue or gums.

2. Advantages of a CBCT Scan over conventional x-rays: A conventional x-ray of your mouth limits your dentist to a two-dimensional or 2D visualization. Diagnosis and treatment planning can require a more complete understanding of complex three-dimensional or 3D anatomy. CBCT examinations provide a wealth of 3D information which may be used when planning for dental implants, surgical extractions, maxillofacial surgery, and advanced dental restorative procedures. Benefits of CBCT scans include: A. Higher accuracy when planning implant placement surgery; B. Greater chance for diagnosing conditions such as vertical root fractures that can be missed on conventional x-ray films; C. Greater chance of providing images and information which may result in the patient avoiding unnecessary dental treatment; D. Better diagnosis of third molar (wisdom teeth) positioning in proximity to vital structures such as nerves and blood vessels prior to removal; E. The CBCT scan enhances your dentist's ability to see what needs to be done before treatment is started.

3. Radiation: CBCT scans, like conventional x-rays, expose you to radiation. In the office of Dr._____, the dose of radiation used for CBCT examinations is carefully controlled to ensure the smallest possible amount is used that will still give a useful result. The dosage per scan is equivalent to 2 regular dental x-rays. However, all radiation exposure is linked with a slightly higher risk of developing cancer. But the advantages of the CBCT scan outweigh this disadvantage.

4. Pregnancy: Women who are pregnant should not undergo a CBCT scan due to the potential danger to the fetus. Please tell the dentist if you are pregnant or planning to become pregnant.

5. Diagnosis of non-dental conditions: While parts of your anatomy beyond your mouth and jaw may be evident from the scan, your dentist may not be qualified to diagnose conditions that may be present in those areas. If any abnormalities, asymmetries, or common pathologic conditions are noted upon the CBCT scan, it may become necessary to send the scan to an Oral and Maxillofacial Radiologist for further diagnosis. However, by signing this form, you are acknowledging that your dentist may not be qualified to diagnose all conditions that may be present, and that his/her liability only extends to the limits of the dental purpose of the scan and its interpretation for that purpose. We are not responsible for interpretation or evaluation of the scan, but are only providing the scan for the evaluation at your dental office.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT, AND AGREE TO ACCEPT THE RISKS AND ADVANGAGES NOTED.

I, _____ being 18 years or older, certify that I have read the above statement. I understand the procedure to be used and its benefits, risks, and alternatives. I have been given the opportunity to have my questions answered, and accept the risks of the CBCT scanning procedure as described above. I therefore give my consent to have Dr._____ and his staff as he may designate, perform a CBCT scan.

Signature of Patient, or Legal Guardian _____Date:_____

CONSENT FOR ORAL SURGICAL TREATMENT IN PATIENTS WHO HAVE RECEIVED ORAL BISPHOSPHONATE DRUGS

Patient name:_____ Date:_____

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

Having been treated previously with oral Bisphosphonate drugs you should know that there is a very small, but real risk of future complications associated with dental treatment. This risk is currently estimated to be less than 2/10 of 1% up to 4%. Bisphosphonate drugs appear to adversely affect the health of jaw bones, thereby reducing or eliminating the jaw bones ordinarily 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 the bone. Spontaneous exposure of the jaw bone (Osteonecrosis) may result. This is a smoldering, long-term, destructive process in the jaw bone that is often very difficult or impossible to eliminate.

Your medical/dental history is very important. We must know the medications and drugs that you have received or taken or are currently receiving or taking. An accurate medical history, including names of physicians is important.

The decision to discontinue oral Bisphosphonate drug therapy before dental treatment should be made by you in consultation with your medical doctor.

_____ 1. If a complication occurs, antibiotic therapy may be used to help control 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, there may be delayed healing, osteonecrosis, loss of bone and soft tissues, pathologic fracture of the jaw, oral-cutaneous fistula (open draining wound), or other significant complications.

_____ 3. If osteonecrosis should occur, treatment may be prolonged and difficult, involving ongoing intensive therapy including hospitalization, 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, the area is always subject to spontaneous breakdown and infection due to the condition of the bone. Even minimal trauma from a toothbrush, chewing hard food, or denture sores may trigger a complication.

_____ 5. Long-term post-operative monitoring may be required and cooperation in keeping scheduled appointments is important. Regular and frequent dental check-ups with your dentist are important to monitor and attempt to prevent breakdown in your oral health.

_____ 6. I have read the above paragraphs and understand the possible risks of undergoing my planned 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. 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 certify that I speak, read and write English and have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my initials or signature.

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

_____ _____
Doctor's Signature Date

_____ _____
Witness' Signature Date

Notes: