_____
Patient's Name

_____
Date of Birth

ESTETICA
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Scottsdale, AZ 85258
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CLOSURE OF SINUS OPENING CONSENT

You have the right to be informed about your condition and the recommended treatment plan. This disclosure is meant to provide information to help you understand the possible risks and complications of treatment, so you may decide to give or withhold your consent.
PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR **BEFORE** INITIALING

1. Your condition involves an abnormal opening (fistula) between the maxillary sinus (a hollow chamber above the roots of upper back teeth) and the mouth. The first stage of your treatment will be (or has been) intensive antibiotic therapy and certain other restrictions in eating and drinking to see if this condition resolves spontaneously. If such does not occur, consideration must be given to surgically close the opening. It is a fairly complicated procedure that includes certain risks. They include, but are not limited to:

___A. Post-operative discomfort and swelling requiring several days of at-home recovery.

___B. Prolonged or heavy bleeding that may require additional treatment. Since the sinus connects to the nose, bleeding may be from the nose.

___C. Injury or damage to tooth roots that are close to the floor of the sinus, possibly requiring later root canal treatment, or even loss of certain teeth.

___D. Mobility (loosening) of certain teeth close to the surgery site.

___E. Post-operative infection that may adversely affect healing and require additional treatment.

___F. Chronic sinus infection may result from this procedure. The sinus is prone to infection and, in many persons, it is difficult to cure. It may be necessary to follow with other sinus procedures to deal with chronic sinusitis, including antibiotics and/or other medications, drainage and other procedures.

___G. Scarring at the site of mouth incisions, which in rare cases may have cosmetic effects on the skin.

___H. Injury to sensory nerves in the jaw or face, resulting in numbness, tingling, pain or other sensory disturbances in the lip, cheek, face, teeth or gums, and which may persist for several weeks or months, or in rare cases may be permanent.

___I. Unusual or adverse responses to drugs and medicines used in the procedure.

___J. Certain fixation devices, (wires, screws, membranes, etc.) may be used in this surgery. They usually remain in place long term, but may require removal in a later separate procedure.

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___K. Closure of sinus fistulas are quite difficult and often several attempts must be made. In some cases more advanced sinus procedures must be attempted before the fistula is closed. There may be more than one closure attempt in your case.

___L. Other procedures may accompany closure of the fistula: placing a drainage hole into the nose, gauze packing that will require removal in several days, as well as other sinus or nasal procedures.

___M. Smoking is very detrimental to healing and you should cease use of tobacco for two weeks before and after this procedure.

___N. Other: _____

___ 2. It has been explained that during the course of surgery unforeseen conditions may be encountered that may require changes in the planned procedure. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

___3. It has been explained to me, and I understand that perfect results cannot be guaranteed. I understand it may take several attempts to close this sinus opening.

___4. It is very important to follow detailed post-operative instructions I will be given – including use of nasal decongestants, antibiotics and other medications; sneezing with my mouth open, not blowing my nose forcefully, and others.

___5. I have read and fully understand this consent for surgery and have had all my questions answered satisfactorily prior to my initials or signature.

Please ask your doctor if you have questions concerning this consent.

Patient's or Legal Guardian's Signature	Date
Doctor's Signature	Date
Witness' Signature	Date

Form EF – 400 – MS – 0103

Patient's Initials _____

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