**Consent for surgery for implants**

**Patient name:** ………………………………………………………………………………………………………

Instructions prior to implant surgery

It is important that you take any prescribed medication as instructed by your doctor. It is also essential that you have a light meal prior to your treatment. Please do not starve yourself.

We will provide you painkillers (and antibiotics if needed) prior and after implant surgery.

Further verbal consent will be taken/confirmed on the day prior to embarking on the treatment.

Instructions after surgery

A full post-surgical instruction pack will be supplied to you.

The majority of patients prefer not to return home using public transport.

It is also recommended that patients do not return to work after surgery and many patients are required to take the following 1-3 days off depending on the complexity of the care.

Name of procedure(s) under local anaesthetic (injection)

1.……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

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3.…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… ……………………………………………………………………………………………………………………………………

Benefits(s) of procedure(s)

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Alternative(s) to procedure(s)

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Additional procedure(s)

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Serious and/or common risks of procedure(s)

Pain, swelling, infection, bleeding, stitches, time off work

The **average** patient requires…………. days off. Please do note that this is an average figure based on our experience of undertaking this procedure and similar procedures regularly. Thus, some patient may require more or less.

The need for painkillers (and antibiotics)

No alcohol for 1 week

Low/Medium/High chance of failure i.e. a lack of integration of bone grafting material and/or dental implant)

Questions:

You confirm that you have read all the written correspondence provided to you prior to this consent form. Please do email my team with any questions between now and the surgery date.

Costs – see letter

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Signature of patient

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Date

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Signature of Surgeon

…………………………………………………………………………………….........

Mr. AJ Ray-Chaudhuri BDS MFDS RCSEd MJDF RCSEng LLM AFHEA FDS RCSEng

Date

…………………………………………………………………………………………………….........

Final check of Medical History O

Fit and well?

Medication?

Allergies?

Intolerances to medications?

Other information?