



SMYRNA DENT

SPACE MAINTAINER INFORMED CONSENT FORM

The objective of this form is to enable your participation into the decision making process about your healthcare by informing you.

This form has been designed in order to meet the needs of many patients under most conditions, nevertheless, it should not be considered as a document containing the risk of the entire applicable treatment. Based upon your individual healthcare, your physician may provide you with different or additional information.

After acquiring the advantages and possible risks of diagnosis, medical treatment and surgical interventions, it is up to your decision whether or not to accept these procedures. You are entitled to refuse to be informed except for the legal and medical necessities or withdraw your consent at any time.

Treatment Modality

In the case where the milk teeth have been lost early, the appliances made to protect the location of the permanent tooth that will cut are called space maintainer. Milk teeth guide the teeth come in on the bottom and as well as provide the function, aesthetics and phonation to the child in the mouth. In cases where the milk teeth are lost early due to cavities, infection, trauma, or any other reason, if the space maintainer is not made, developmental disorders and crowding may occur in the mouth.

The space maintainers are of two types as fixed and removable. The measurement taken from inside of the child's mouth is sent to laboratory and a space maintainer is made suitable for the teeth. The fixed space maintainer is applied to the teeth and the removable type adjusts to the teeth, and is controlled by the dentist every 6 months until the permanent teeth come in behind them. It doesn't cause any harm to the child and does not interfere with chewing.

Care of The Space Maintainers

The fixed space maintainer is brushed as it is done in normal mouth and dental care. Sticky foods such as chewing gum and Turkish delight should be avoided.

Removable space maintainer should be taken out during meals. After meal, it should be brushed and placed in the mouth. Especially the school-age children lose space maintainers during a meal at school. Therefore, they should carry their special boxes with them. The space maintainer should be placed in that box as soon as it leaves the mouth.



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Diagnosis _____

Treatment/procedure to be applied _____

Side/grade if applicable Right sided Left sided Both sided Grade _____

Should you not intend to be informed about the purpose, duration, advantages, success ratio, potential risks and complications and alternative options of the treatment to be applied and as well as about the subsequent potential risks in case you do not accept the treatment, please declare so below with your hand writing.

I hereby declare that;

My attending physician informed me about my disease, the treatment option to be applied, its duration, advantages, success ratio, the fact that it does not necessarily guarantee the recovery of current status, period of healing, potential risks and complications, alternative techniques, the potential situations I will experience on the condition that I reject the treatment and compulsory performance of an additional operation/intervention/procedure if deemed necessary and s/he answered all my questions regarding these matters.

Above mentioned procedure has been disclosed to be performed on myself/patient I legally represent by the physicians, nurses as well as other healthcare professionals under the authority, surveillance and control of my attending physician.

I have been informed that if required, anesthesia will be performed by an anesthetist, sedation will be performed by an anesthetist or another physician competent in sedation and local anesthesia will be performed by my attending physician.

While being entitled to make decision and think straightly, I accept the medical procedure to be performed, and consent that my attending physician and his/her team will carry out any medical treatment option/surgical technique/intervention they deem to be necessary.

I authorize the hospital to examine, inspect, dispose of or keep the tissues or organs removed during the procedure for which I have consented above.

I allow my medical reports to be used for scientific researches provided that my identifying information is kept hidden.

Patient's			
Full Name:	Signature:	Date:	Time:
Date of Birth:			
Legal Representative's			
Full Name:	Signature:	Date:	Time:
Degree of Relationship:			
Reason why the consent is delivered by legal representative of the patient:			
<input type="checkbox"/> Patient is not conscious	<input type="checkbox"/> Patient is under 18		
<input type="checkbox"/> Patient is not entitled to make decision	<input type="checkbox"/> Emergency		
Witness'			
Full Name:	Signature:	Date:	Time:
Informing Physician's			
Full Name:	Signature:	Date:	Time:
Interpreter's (If required)			
Full Name:	Signature:	Date:	Time:

Informed consent is delivered by the patient himself/herself if s/he is older than 18 years old, by the patient himself/herself together with his/her legal representative if the patient is aged between 15 and 18 and by the representative of the patient if the patient is under 15 years old and/or is unconscious and/or is not entitled to make decision and in case of emergency.