

## CONSENT FOR ARTHROCENTESIS OF THE TEMPOROMANDIBULAR JOINT (TMJ)

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Patient's Name

Date

You have the right to be informed about your condition and the recommended treatment so that after knowing the risks and hazards involved you may make an informed decision of whether or not to undergo the procedure. This disclosure is not meant to alarm you; it is an effort to properly inform you so that you may give or withhold your consent.

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

1. Dr. \_\_\_\_\_ has explained to me the pathology (disease) that exists in my jaw joint (TMJ, temporomandibular joint). I understand that this procedure is somewhat exploratory in nature and is being done in an effort to alleviate symptoms of pain and limitation of motion of my jaw joints. Frequently, the procedure may be accompanied by the use of medication and occlusal splint therapy and physical therapy.
- \_\_\_2. The arthrocentesis procedure has been described to me. I understand that it is performed by inserting a small needle just in front of my ear through the skin and directly into the jaw joint to irrigate and clean the inside of the joint. In addition, a steroid medication solution or other medications may be injected into the joint space. On rare occasions, patients react to the steroid medication by adverse changes in the bone of the ball of the joint.
- \_\_\_3. I further understand that a more involved procedure may be required depending upon my response to this procedure. These procedures could involve repeat arthroscopic surgery or open joint surgery.
- \_\_\_4. I have been informed of alternative methods of treatment for my condition which include: no treatment, physical therapy, medication therapy, splint therapy, arthroscopic surgery, and open joint surgery.
- \_\_\_5. I have been made aware that certain side effects and complications can result from arthrocentesis and that these may include but are not limited to the following:
  - \_\_\_A. Temporary or permanent facial muscle weakness resulting from motor nerve injury during the injection. The most common problem resulting is the inability to wrinkle the brow, raise the eyebrow or gain tight closure of the eyelids.
  - \_\_\_B. Numbness (temporary or permanent) of certain areas of skin in the region of the joint and sometimes in more remote areas of the face or scalp.
  - \_\_\_C. Bleeding within the joint which cannot be adequately controlled and could require intervention by open joint surgery.
  - \_\_\_D. Ear problems, including inflammation of the canal, middle or inner ear infections, perforation of the ear drum and temporary or permanent hearing loss.
  - \_\_\_E. Instrument separation which may require open joint surgery.
  - \_\_\_F. Facial scarring from the entry injection.
  - \_\_\_G. Damage to the joint surface during the arthrocentesis or needle procedure, usually of a reversible nature but which could permanently affect joint function.

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- \_\_\_H. Unsuccessful entry into the joint or inability to accomplish the desired procedure because of limited motion of the joint or scarring.
  - \_\_\_I. Worsening of present TMJ symptoms which may require repeat **arthrocentesis** arthroscopy or open joint surgery.
  - \_\_\_J. Changes in the bite after arthrocentesis which may affect chewing functions. In addition, there may be temporary or permanent limited mouth opening.
  - \_\_\_K. Post-operative infection requiring additional treatment.
  - \_\_\_L. Adverse or allergic reactions to any of the medications used in the procedure.
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- \_\_\_6. I understand that all of my current symptoms may not change after this procedure and that future treatment may require additional physical therapy, splint therapy, restorative dentistry, orthodontics (braces), additional jaw surgery or future reconstruction of the TMJ including implant devices or bone grafting.
  - \_\_\_7. I agree not to use non-prescribed drugs and not to participate in contact sports, water sports, and strenuous physical activity for six weeks following arthrocentesis.
  - \_\_\_8. I agree to fully comply with the recommendations of Dr. \_\_\_\_\_, realizing that a lack of cooperation may result in less than optimal results. I understand that there can be no warranty or guarantee as to the result **and/or** cure, and that my condition may return or become worse after arthrocentesis.
  - \_\_\_9. I have had the opportunity to discuss my past medical history and dental history with my doctor, including medical or health problems, drug and alcohol use, and any other information that may affect this procedure.

I certify that I speak, read and write English, I fully understand this consent form for arthrocentesis, and that all blanks were filled in prior to my initialing and signing this form. I have been given the opportunity to obtain a second opinion from a qualified professional regarding this proposed procedure. I have also been given the opportunity to ask questions and have been given answers to the questions which satisfy me.

PLEASE CLARIFY ANY QUESTIONS WITH YOUR DOCTOR BEFORE SIGNING.

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Patient's (or Legal Guardian's **Signature**)

Date

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Doctor's Signature

Date

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Witness's Signature

Date