21 DENTAL GROUP

Discussion and Informed Consent for Root Canal Retreatment

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment and Tooth Number(s): _____

Facts for Consideration

Patient's initials required

_____ Root canal retreatment, also called *endodontic retreatment,* involves treating a tooth with a previous root canal that did not respond successfully to the initial treatment or has developed a new problem. This happens at times, as no medical or dental treatment has 100 percent success rate. Retreatment involves creating an opening through the biting surface of the tooth to expose the previous root canal filling, which is then removed. Medications may be used to disinfect the interior of the tooth to prevent further infection. Root canal retreatment may relieve symptoms such as pain and discomfort.

_____ Each previously treated root canal that can be located is cleaned and refilled. Sometimes an additional canal is present, but cannot be located. Occasionally, a post is also inserted into the canal to help support and restore the tooth. The opening in the tooth is closed with a temporary filling. At a later appointment, a new (or initial) crown or filling may be placed, which is a separate dental procedure not included in this discussion.

_____ Twisted, curved, accessory or blocked canals may prevent removal of all previous root canal filling. Because leaving any pulp in the root canal may cause your symptoms to continue or worsen, an additional procedure called an apicoectomy may be required. Through a small opening cut in the gums and surrounding bone, any infected tissue is removed and the root canal is sealed. An apicoectomy may also be required if your symptoms continue and the tooth does not heal.

_____ Once the root canal retreatment is completed, it is essential to return promptly to begin the next step in treatment. Because a temporary seal is designed to last only a short time, failing to return as directed to have the tooth sealed permanently and protected with a crown or filling can lead to other problems, such as the need to repeat the treatment at an additional cost and deterioration of the seal, resulting in decay, infection, gum disease, fracture and the possible loss of the tooth.

_____ Even in cases with no complications where a crown or filling is placed right away, this procedure will not prevent future tooth decay, tooth fracture or gum disease; occasionally, a tooth that has had root canal treatment may require endodontic retreatment, endodontic surgery or extraction. Strict home care must be followed.

Benefits of Root Canal Retreatment, Not Limited to the Following:

_____ Root canal retreatment is intended to correct a condition that developed after the initial root canal treatment or did not resolve after your initial root canal treatment to allow you to keep your tooth for a longer time, which will help to maintain your natural bite and the healthy functioning of your jaws. This treatment may also be recommended to relieve the symptoms of the diagnosis described above.

Risks of Root Canal Retreatment, Not Limited to the Following:

_____ I understand that following treatment I may experience bleeding, pain, swelling and discomfort for several days, which may be treated with pain medication. It is possible infection may accompany root canal retreatment and must be treated with antibiotics. I will immediately contact the office if conditions worsen or if I experience fever, chills, sweats, numbness, sinusmproblems, severe pain or swelling.

I understand that I may receive a local anesthetic and/or other medication. In rare instances, patients have a reaction to the manesthetic or find that it reduces their ability to control swallowing, which may require emergency medical attention. Lack of control of swallowing increases the chance of swallowing foreign objects during treatment. **Depending on the anesthesia and medications administered, I may need a designated driver to take me home.** Rarely, temporary or permanent nerve injury causing numbness of the oral cavity and or face including the lips, chin, cheeks, gums, teeth or tongue, including loss of part of the sense of taste, can result from an injection.

I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications and supplements I am currently taking, which are:

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days; this is sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

I understand that occasionally a root canal instrument may break off in a root canal that is twisted, curved or blocked with calcium deposits. Depending on its location, the fragment may be retrievable or it may be necessary to seal it in the root canal (these instruments are made of sterile, nontoxic surgical stainless steel and usually cause no harm). It may also be necessary to perform an apicoectomy, as described above, to seal the end or lower part of the root canal.

I understand that during treatment the root canal filling material may extrude out the root canal into the surrounding bone and tissue. Occasionally, an apicoectomy may be necessary for retrieving the filling material and sealing the root canal.

I understand that other complications that may occur include, but are not limited to,0 perforations (extra openings) of the canal by an instrument, blocked root canals that cannot be ideally cleaned and filled, fracture, chipping or loosening of existing tooth or crown, requiring replacement at an additional cost. I may also experience temporary or permanent numbness or painful nerve sensations.

I understand teeth that receive root canal treatment may be more prone to cracking and breaking over time and teeth may require removal and replacement with a bridge, partial denture or implant. In some cases, root canal retreatment may not relieve all symptoms. The presence of gum disease (periodontal disease) can increase the chance of losing a tooth even though root canal retreatment was successful.

I understand that root canal retreatment may not succeed in relieving all of my symptoms and I may need my tooth extracted.

Consequences if No Root Canal Retreatment Is Administered, Not Limited to the Following:

I understand that if I do not have root canal retreatment, any discomfort I may have might continue and I may face the risk of a serious, potentially life-threatening infection, abscesses in the tissue and bone surrounding my teeth and eventually the loss of my tooth and/or adjacent teeth.

Alternative Treatments if Root Canal Retreatment Is Not the Only Solution, Not Limited to the Following:

I understand that depending on my diagnosis alternatives to root canal retreatment may exist that involve other disciplines in dentistry. Extracting my tooth is the most common alternative to root canal retreatment. An apicoectomy may be an alternative to retreatment. Extraction may require replacing the tooth with a removable or fixed bridge or an implant, each supporting an artificial tooth or teeth. I have had an opportunity to ask my dentist about the alternatives and associated expenses. My questions have been answered to my satisfaction regarding the procedures, their risks, benefits, alternatives and costs.

Alternatives discussed:

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition (s) listed above.

Check the boxes below that apply to you:

Consent

☐ I have been informed both verbally and by the information provided on this form of the risks and benefits of the proposed treatment.

☐ I have been informed both verbally and by the information provided on this form of the material risks and benefits of alternative treatment and of electing not to treat my condition.

☐ I certify that I have read and understand the above information and that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

_____ _____

Patient or Patient's Representative Date

_____ _____

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

_____ _____

Dentist Signature Date