Drawing Blood and Platelet Rich Fibrin (PRF) for use in dental surgery

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_____ _____

Patient's Name Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor is available to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Procedure: _____

Dr. has recommended the use of Platelet Rich Fibrin (PRF) to enhance post-operative healing. PRF is a component of my own blood. Blood contains platelets, which contain growth factors that help stimulate soft tissue healing.

I will have several vials of my own blood drawn to be placed in a centrifuge to concentrate the platelets. This helps them to activate and release their growth factors.

All blood drawing materials, needles, and all the centrifuge processing containers are single use. They are all disposed of in a medical waste container after each patient. Each PRF procedure uses its own sterile materials and supplies.

I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand and accept the use of tobacco and alcohol is detrimental to the success of my treatment and will comply with my doctor's instructions.

I understand and agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible

Patient's Initials _____

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risks and complications of the procedure and agree to proceed. If I am sedated or under general anesthesia during the procedure, I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

_____ _____
Patient or Legal Representative Signature Date

_____
Print Patient or Legal Representative Name/Relationship

_____ _____
Witness to Patient Signature Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

_____ _____
Doctor Signature Date