OWEN SOUND
DENTAL CLINIC

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Informed Consent for: Endodontic (Root Canal) Treatment

. The goal of Root Canal Treatment is to save a tooth that might otherwise require Extraction. Although Root Canal Treatment has a very high success rate, as with all medical and dental procedures, the results cannot be guaranteed. Root Canal Treatment is performed to correct an apparent problem, and occasionally an unapparent tooth fracture or gum disease. Occasionally a tooth that has been Root Canal Treated may require a Re-Treatment, Endodontic Surgery, or Extraction.

Risks:

The Following are **Unlikely** Risks that may occur:

- Instrument Separation in the canal
- Perforations (extra openings) of the canal with instruments
- Blocked canals that cannot be ideally completed
- Incomplete healing
- Post-Operative infection requiring additional treatment or the use of antibiotics
- Tooth and/ or root fracture that may require extraction
- Fracture, chipping, or loosening of existing tooth or crown
- Post-treatment discomfort/ pain
- Temporary or permanent numbness
- Change in bite or jaw joint difficulty (TMJ problems or TMD)
- Medical problems may occur if Root Canal Treatment is left unfinished
- Reactions to anaesthetics (freezing), chemicals or medications used
- Referral to an Endodontist (Root Canal Specialist) if necessary

Other Treatment Options:

The following are other treatment options that might be possible:

- No Treatment at all, with risk of continued pain/ recurrent infection
- Waiting for more definitive development of symptoms
- Extraction:
  - To be replaced with nothing, a bridge, denture, or implant.

After the completion of the Root Canal Treatment, you will need a permanent restoration (filling with a post and/ or Crown). A Crown is always the most definitive option to prevent fracturing of the tooth.

I have had an opportunity to discuss and ask any questions to my Dentist (service provider), and I am satisfied with the answers that I have received.

I therefore Consent to this procedure.

Date: ____________________	Tooth#: ____________________
Patient Name: ____________________	Patient Signature: ____________________
Prognosis: ____________________	Dentist: ____________________