PROCEDURE DETAILS & INFORMED CONSENT FORM FOR PEDIATRIC PULP THERAPY

Name of the concerned doctor : **Date:**

Patient name :

Age: **Gender:**

Parent name:

Address for communication:

Contact number: **Email Id:**

Chief complaint:

Medical history :

Past dental history :

Clinical finding:

Treatment plan (Pediatric pulp therapy) :

Direct pulp capping:

With respect to tooth number:

Medicament used:

Procedure details:

Indirect pulp capping:

With respect to tooth number:

Medicament used:

Procedure details:

Pulpotomy:

With respect to tooth number:

Medicament used:

Procedure details:

Pulpectomy:

With respect to tooth number:

Medicament used:

Procedure details:

Apexification:

With respect to tooth number:

Medicament used:

Procedure details:

Apexogenesis:

With respect to tooth number:

Medicament used:

Procedure details:

Revascularisation:

With respect to tooth number:

Medicament used:

Procedure details:

Root canal treatment:

With respect to tooth number:

Medicament used:

Procedure details:

Note:

Medicament to be used for specific pediatric pulp therapy can vary from what has been mentioned above based on the case scenario and cooperation of the patient .

Success of any pediatric pulp therapy procedure depends on the post treatment restoration, regular follow up and pathological factors.

Above mentioned demographic and medical history details provided by me are correct. I understand the condition of the concerned tooth and treatment plan made with respect to the same tooth. The details of specific pediatric pulp therapy procedure to be performed including medicament to be used has been explained to me thoroughly. I give my consent to go ahead with the above-mentioned treatment plan.

Patient Signature:
Date:

Parent Signature(In case of minor):
Date: