# *Informed Consent for Phelebotomy/PRP(PDGF),PRF(L-PRF) Development*

After careful dental/medical examination of my condition, my dentist has recommended the use of Platelet Rich Plasma (PRP) and/or Platelet Rich Fibrin (PRF) to enhance post- operative healing. PRP/PRF is a component of my own blood that contains growth factors. These growth factors are known to stimulate soft tissue healing. I understand that PRP/ PRF is processed from my own blood and is therefore safe from disease transmission.

I understand that in order to process **PRP** there will be a 20ml-55ml (about ½ cup of coffee) blood draw from a vein using an aseptic technique. My blood will be mixed with an anticoagulant and placed in a centrifuge to concentrate the platelets, then mixed with sterile bovine (cow) thrombin and sterile Calcium Chloride to activate the platelets (make them release their growth factors).

I understand that in order to process **PRF** there will be several vials of blood drawn. My blood will be placed in a centrifuge to concentrate the platelets. This will activate the platelets (make them release their growth factors).

All blood drawing materials and needles, all the centrifuge processing containers and calcium chloride containers, and mixing/activating syringes are single use and are disposed in our medical waste containers after each patient. Each PRP/PRF procedure uses its own sterile materials and supplies.

Risks and Complications of the blood draw for the PRP/PRF include: Pain on the draw entry, bruising, may become lightheaded, inflammation of the vein and rare risk of infection.

I have been fully informed about the use of PRP/PRF, the procedure(s) to be utilized for development, the risks, benefits and alternatives. I have had an opportunity to ask questions and to discuss any concerns with my dentist. After thorough deliberation, I hereby fully consent to the PRP process.

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT**

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**Signature of Patient or Guardian** **Date**

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**Signature of Witness** **Date**

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**Signature of Doctor** **Date**