



**MASON & MASON**  
**DENTISTRY PA**

**Platelet Rich Fibrin (PRF) Informed Consent**

After careful examination of my condition, my dentist has recommended the use of Platelet Rich Fibrin (PRF) to enhance post-operative healing. 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 PRF is processed from my own blood and is therefore safe from disease transmission.

I will have several vials of my own 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).

I understand that 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 of in medical waste containers after each patient. Each PRF procedure uses its own sterile materials and supplies.

Risks and Complications of the blood draw for the PRF include but are not limited to: Pain at the draw entry, bruising, lightheadedness, inflammation of the vein and rare risk of infection.

Contraindications: There are very few contraindications, however, patients with the following conditions are not candidates: acute and chronic infections, cancer, chemotherapy treatments, severe metabolic and systemic disorders, abnormal platelet function, blood disorders, chronic liver pathology, anti-coagulation therapy, underlying sepsis and systemic use of corticosteroids within two weeks of the procedure. Smoking inhibits the body's ability to heal and can significantly compromise surgical outcomes.

My consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, I agree that I have read this informed consent and certify I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I agree to adhere to all safety precautions and instructions after the treatment. I have been instructed in and understand post treatment instructions and have been given a written copy of them. I understand that medicine is not an exact science and acknowledge that no guarantee has been given or implied by anyone as to the results that may be obtained by this treatment.

I have been fully informed about the use of 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 PRF process.

I certify that I have read this document.

Patient name printed: \_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_

Witness name printed: \_\_\_\_\_

Witness signature: \_\_\_\_\_

Date: \_\_\_\_\_