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Patient Name

INFORMED CONSENT FOR CONSCIOUS SEDATION

The purpose of this document is to provide an opportunity to understand and give permission for conscious sedation when provided along with dental treatment. Each item listed below will need to be initiated after adequate opportunity for discussion and questions.

_____ 1. I understand that the purpose of conscious sedation is to more comfortably receive my dental care. Conscious sedation, however, is not a requirement in most circumstances to provide those necessary services.

_____ 2. I understand that conscious sedation is a drug-induced state of reduced awareness and decreased ability to respond. Conscious sedation is not sleep. I will be able to respond during the procedure. My ability to respond normally returns when the effects of the sedative wear off.

_____ 3. I understand that my conscious sedation will be achieved by the following route:

_____ Oral Admininstration _____ Inhalation Administration

_____ Intravenous Administration _____ Combination of Techniques

_____ 4. I understand the alternatives to conscious sedation are:

_____ a. No sedation: The necessary procedure is performed under local anesthetic with the patient fully aware.

_____ b. Anxiolysis: Taking a pill to reduce fear and anxiety.

_____ c. Nitrous Oxide Sedation: Commonly called laughing gas, nitrous oxide provides relaxation but one is still generally aware of surrounding activities. Its effects can be reversed in five minutes with oxygen.

_____ d. General Anesthesia: commonly called deep sedation, a patient under general anesthesia has no awareness and must have their breathing temporarily supported. General anesthesia is more appropriate in an oral surgical or hospital environment.

_____ 5. I understand that there are risks or limitations to all procedures. For sedation these include:

_____ a. Inability to discuss treatment options with the doctor should circumstances require a change in your treatment plan.

_____ b. A typical reaction to sedative drugs which may require emergency medical attention and/or hospitalization such as altered mental states, physical reactions, allergic reactions, and other sicknesses. Nausea, vomiting, delayed recovery, excessive sedation, and vascular irritation are common risks.

_____ 6. If, during the procedure, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

_____ 7. I have had the opportunity to discuss conscious sedation and have my questions answered by qualified personnel including the doctor, I also understand that I must follow all the recommended treatments and instructions of my doctor.

_____ 8. I understand that I must notify the doctor if I am pregnant, or if I am lactating. I must notify the doctor if I have sensitivity to any medication, of my present mental and physical condition, if I have recently consumed alcohol, and if I am presently on psychiatric mood altering drugs or other medications.

_____ 9. I will not be able to drive or operate machinery for 24 hours following my sedative procedure. I understand I will need to have arrangements for someone to drive me to and from my dental appointment.

_____ 10. I hereby consent to conscious sedation in conjunction with my dental care.

_____ _____ _____
Patient/Guardian Date Witness