

CONSCIOUS ORAL SEDATION INFORMED CONSENT FORM



The purpose of this document is to provide an opportunity for you to understand and give permission for conscious sedation when provided along with dental treatment. Each item should be checked off after the patient has had an opportunity for discussion and questions.

_____ 1. I understand that the purpose of conscious sedation is to more comfortably receive necessary care. Conscious sedation is not required to provide the necessary dental care. I understand that conscious sedation has limitations and risks and absolute success cannot be guaranteed.

_____ 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 administration: I will take a pill approximately _____ minutes before my appointment. The Sedation will last approximately _____ to _____ hours

_____ 4. I understand that 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.

_____ 5. I understand that there are risks or limitations to all procedures.

For sedation these include:

_____ (Oral Sedation) Inadequate sedation with initial dosage may require the patient to undergo the procedure without full sedation or delay the procedure for another time.

_____ Atypical 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.

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

_____ 6. If, during the procedure, a change in treatment is required, I authorize the doctor and 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 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 while taking oral sedatives for 24 hours after my procedure. I understand I will need to have arrangements for someone to drive me to and from my dental appointment while taking oral sedatives.

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

Patient/Guardian

Date

Witness

CONSENT TO ADMINISTER LOCAL ANESTHETIC

During the administration of local anesthetic you may feel what appears as an electric shock. This usually happens with lower injections. In rare cases when this occurs numbness may be prolonged-most cases just a few hours in very rare cases permanently.

SIGN_____ **DATE**_____

Patients & Guardians Should Be Told Before Their Appointment:

- ☐ No food or liquids (except sip of water for meds) for eight hours prior to treatment.
- ☐ No sedatives for 24 hours before/after (other than night time anxiolytic prescribed by treating dentist)
- ☐ No stimulants for 12 hours before/after
- ☐ No chance of pregnancy
- ☐ No sensitivities to Benzodiazepines, Hydroxyzine, Zaleplon
- ☐ Must have a responsible adult to transport and monitor for at least 3 hours.
- ☐ No contact lenses

Patients Should Be Told Before That Following Their Appointment

- ☐ No driving for driving for 24 hours after
- ☐ No operating hazardous devices
- ☐ No heavy lifting
- ☐ No stairs
- ☐ No important decisions

Printed Name_____ **Date**_____

Signed Name_____ **Date**_____

Ride must stay in the office for the length of the appointment.

Ride Sign_____ **Date**_____