Informed Consent for Oral Conscious Sedation

The following is provided to inform patient, or the parent/guardian of a patient under the age of 18 years, of the choices and risks involved with having treatment under conscious sedation. This information is presented to enable them to be better informed concerning their treatment. The type of sedation administered will be determined on an individual basis. The choices of anesthesia are local anesthesia alone, Oral Conscious Sedation, and/or nitrous oxide inhalation sedation. The most commonly used sedative is Triazolam (halcyon). Although usually prescribed as a sleeping pill, Triazolam is a medication that can greatly minimize anxiety that may be associated with going to the dentist. In a relaxed state, you will still be able to communicate with the dentist while treatment is being performed. Even though it is safe, effective, and wears off rapidly after the dental visit, you should be aware of some important precautions and considerations:

NOTE: This consent form and dental treatment consent form should be signed before you take the medication. They are invalid if signed after you take the pills. Please initial each of the sections below as you review them. Be sure to ask any questions you may have.

_____ I understand that the purpose of sedation is to more comfortably receive care. I understand that sedation is **not required**. I understand that sedation has limitations and risks and absolute success cannot be guaranteed. I understand there are other alternatives to sedation dentistry to include NO sedation or IV sedation.

_____I am not taking the following medications: Serzone (nefazidibe), Tagamet or Peptol (cimetidine), Levodopa for Parkinson's disease, antihistamines such as Benadryl or Tavist, verapamil, Cardizem (diltiazem), erythromycin, antimycotics (Nizoral, Biaxin, or Sporanox), HIV drugs indinavir or nelfinovir, recreational/street drugs, nor alcohol.

_____I do not have a history of hypersensitivity to benzodiazepines (Valium, Ativan, Versed, etc.) nor do I have liver and kidney dysfunctions.

_____I have been informed and understand that occasionally there are complications of the sedation medications including but not limited to minor conditions such as: pain, nausea, vomiting, light headedness, headache, amnesia, allergic reaction, visual disturbances; to serious adverse problems such as respiratory depression which can be fatal. I further understand and accept the risk that complications may require hospitalization. I have been made aware that the risks associated with local anesthesia, conscious sedation and inhalation sedation vary. The most frequent side effects are drowsiness, nausea, and vomiting.

_____I understand that anesthetics, medications and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Elma Family Dental of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement

of anesthesia. For the same reason I understand that I must inform Elma Family Dental if I am a nursing mother.

_____Inadequate initial dosage may require the patient to undergo the procedure without sedation, delay the procedure for another time, or extend current appointment time and take additional medications.

_____Nitrous Oxide inhalation may be used in conjunction with oral medications and local anesthetics.

_____I understand that during the procedure, a change in treatment may be required. I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I authorize the doctor to discuss my care and instructions with my designated escort. I understand that I have the right to designate the individual who will make such decisions:
_____.

_____I understand that sedation is a drug-induced state of reduced awareness and decreased ability to respond. The onset of Triazolam is 15 to 30 minutes, the peak effect is at 1 to 2 hours and the duration is 1-6 hours. I will have a driving escort before and after treatment. I will have a care taker/escort for a minimum of four to six (4-6) hours after treatment.

_____I understand that it is WA state law and Elma Family Dental protocol for us to utilize a wheelchair to take you to your vehicle, ensure that you are reclined, seat belted in, and the designated driver is escorting you home.

_____Because multiple medications may cause drowsiness, I have been advised not to operate any vehicle or hazardous device for at least 12 hours post anesthesia. I will not take any post operative narcotics until 8 hours after completion of my procedure.

_____I have been advised not to make any major or important decisions until after full recovery from the anesthesia. I understand that those with a history of chemical dependency have a risk of relapse after anesthesia and should take appropriate precautions.

I hereby authorize and request Elma Family Dental to perform the sedation previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned sedation. I consent, authorize and request the administration of such sedation methods (from local to inhalation). Elma Family Dental and Dr. Katherine Ketcher's sole attention and responsibility will be to render the optimal and safest dental sedation possible with the state of the art continuous monitoring medical equipment.

I have been fully advised of and accept the possible risks and dangers of sedation. I also completely understand the alternatives to Sedation. I acknowledge the receipt of and understand both the pre-operative and post-operative sedation instructions. It has been explained to me and I understand that there is no warranty or guarantee as to any result and/or cure. I have had the opportunity to ask questions about my sedation and I am satisfied with the information provided to me.

I have received and understand the Pre-Anesthesia, Day of Surgery, and the Post-Anesthesia Instruction Sheet, the Financial Form and the Transportation Information Form.

Signed_____
Date_____
Circle one Patient, Parent, or Guardian

Print name_____
Witness_____

Dentist signature_____
Assistant signature_____