Informed Consent for Conscious Oral Sedation

To be completed by patient. If patient is under 18, parent or guardian must sign.

Patient Name: _____

The purpose of this document is to provide an opportunity for patients to understand and give permission for conscious sedation when provided alongside dental treatment. Each item should be **initialed by the patient or parent/guardian** once the patient or parent/guardian has had the opportunity for discussion and questions.

_____1. I understand that the purpose of conscious sedation is to make the procedure more comfortable. Conscious sedation is not required to provide the necessary care. I understand that conscious sedation has limitations and risks and that 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 will return to normal when the effects of the sedation wear off.

_____3. I understand that my conscious sedation will be achieved by the following route:

Oral Sedation

_____4. I understand that the alternatives to Conscious Sedation include:

No Sedation…. Nitrous Oxide…. IV Sedation….General Anesthetic

_____5. I understand that there are **risks, limitations, and complications** to all procedures. For Conscious Sedation these include, but are not limited to: discomfort, swelling, bruising, infection, allergic reactions, and nausea. There may be episodes of enhanced anxiety or panic with Nitrous Oxide sedation. There may be inadequate sedation with the Oral route, which may require the patient to undergo the procedure without full sedation or delay the procedure for another time. Nausea and vomiting, although uncommon, may be unfortunate side effects of sedation

_____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, to be necessary. I understand that I have the right to designate the individual who will make such a decision.

_____7. I understand that under conscious sedation medical emergencies may arise. I authorize the doctor and the operative team to administer any medications deemed necessary to aid in the medical emergency. I also authorize for any adjunctive measures needed to help with the medical emergencies as well.

_____8. I have had the opportunity to discuss conscious sedation and to have my questions answered by qualified personnel including the doctor. I also understand that I must follow all of the recommended treatments and instructions of my doctor.

_____9. 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 or recreational drugs, and if I am presently on psychiatric mood altering drugs or other medications.

_____10. I will not be able to drive or operate any 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.

I hereby acknowledge that I read and understand English.

I hereby consent to the use of Conscious Sedation in conjunction with my dental care.

Patient/Parent/Guardian Signature: _____

Date: _____

Doctor Signature: _____

Date: _____