CONSCIOUS SEDATION INFORMED CONSENT FORM

The purpose of this document is to provide an opportunity for patients to understand and give permission for conscious sedation when provided along with dental treatment. Each item should be checked off after the patient has the 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 Oral administration: I will take a pill approximately 60 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 but, are not limited to;

A._____ Inadequate sedation with initial dosage may require that patient to undergo the procedure without full sedation or delay the procedure for another time.

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.

C._____ 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 decisions.

7._____I have had the opportunity to discuss conscious sedation and have had 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.

8._____I understand that I must notify the doctor if I am pregnant, of if I am lactating. I must notify the doctor if I have the 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. I rare cases when this occurs , numbness may be prolonged –most cases, just a few hours-in very rare cases, permanently.

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