

Consent to Intra-Venous Sedation

Diagnosis: I have been informed that my treatment can be performed with a variety of types of anesthesia. These include local anesthesia as normally used for minor dental treatment, oral sedation, IV conscious sedation, and general anesthesia. My dentist has recommended IV conscious and/or oral sedation in addition to local anesthetic for one of the following reasons:

- . 1) a long and possibly stressful procedure is to be undertaken
- . 2) certain medical or physical conditions of mine may indicated sedation
- . 3) I am subject to significant anxiety and emotional stress related to dental procedures

Recommended Treatment: I understand that in IV conscious sedation, small doses of various medications will be administered to produce a state of relaxation, reduced perception of pain, and drowsiness. However, I will not be put to sleep as with a general anesthetic. In addition, local anesthetics will be administered to numb the areas of my mouth to be operated. I understand that the medications to be used may include Halcion, Versed and/or narcotics such as Fentanyl or Demerol, I recognize that I must do several things in connection with IV conscious sedation. Specifically, I must refrain from eating for six (6) hours before my dental appointment(s). I must not drink any alcoholic beverage. That day, I will arrange for a responsible adult to drive me to the appointment, remain in the office during my procedure, and drive me home and stay with me until the effects of the sedation have worn off. I will not drive a motor vehicle or operate dangerous machinery on the day(s) that I receive the sedation.

Expected Benefits: The purpose of IV conscious sedation is to lessen the significant and undesirable side effects of a long or stressful dental procedure. This is done by chemically reducing the fear, apprehension, and stress sometimes associated with these procedures.

Principal Risks and Complications: I understand that occasionally complications may be associated with IV conscious sedation. These include pain, swelling, bruising, inflammation of the vein (phlebitis), infection, bleeding, discoloration, nausea, vomiting, and allergic reactions. I further understand that, in extremely rare instances, damage to the brain and even death, can occur. To help minimize risks and complications, I have disclosed to my dentist any and all drugs and medications that I am taking. I have also disclosed any abnormalities in my current physical status or past medical history. This includes any history of drug or alcohol abuse and any reactions to medications or anesthetics.

Alternatives to Suggested Treatments: Alternatives to IV conscious sedation include local anesthesia, oral sedation, and general anesthesia. Local anesthesia and oral sedation may, however, not adequately dispel my fear, anxiety, or stress. There may be less control of proper dosage with oral sedation than with IV conscious sedation. General anesthesia will require use of an anesthesiologist and involve additional risks. **Necessary Follow-up Care:** I understand that I must refrain from drinking alcoholic beverages and taking certain medications for a twenty-four (24) hour period following the administration of IV conscious sedation (your dentist will decide if you medication dosages need to be temporarily changed). I also understand that a responsible adult will drive me home and remain with me until the effects of the sedation have worn off and that I will not drive or operate dangerous machinery for the remainder of the day(s) on which I receive sedation.

No Warranty of Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. I recognize that, as noted above, there are risks and potential complications in the administration of IV conscious sedation.

PATIENT CONSENT

I have been informed of the nature of IV conscious sedation, the procedure(s) to be utilized, the risks and benefits of this form of sedation, the alternatives available, and the necessity for follow-up. I have had an opportunity to ask question I may have in connection with the procedure(s) and to discuss my concerns with my dentist I hereby consent to the IV conscious sedation procedure(s) as presented to me during consultation and in the treatment plan for my periodontal needs.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

Date	Printed Name of Patient, Parent, or Guardian	Signature
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Date	Printed Name of Witness	Signature
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Date	Printed Name of Doctor	Signature
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