Consent for IV Conscious Sedation

Patient Name ____

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, local anesthesia supplemented with Nitrous Oxide/Oxygen (laughing gas), local anesthesia supplemented with IV conscious sedation and general anesthesia in the hospital or out-patient surgical center. I desire to have the doctor use IV conscious sedation during this procedure.

Recommended Treatment: I understand that in IV conscious sedation, small doses of various medications will be administered through an IV line in one of my veins 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 and thus further control pain. I understand that the drugs to be used may include <u>valium, versed and nubain.</u>

I understand that I must do several things in connection with IV conscious sedation. Specifically, I must refrain from eating for four (4) hours before my dental appointment. I must not drink any alcoholic beverage or take certain medications for twelve (12) hours before and twenty-four (24) hours after the procedure. Further, I will arrange for a responsible adult to drive me home and stay with me until the effects of the sedation have worn off. I will not drive a motor vehicle, operate dangerous machinery, handle sharp objects, or make any financial decisions on the day that I receive the sedation.

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

Principal Risks and Complications: I understand that occasionally complications may be associated with IV conscious sedation. These include pain, facial swelling or bruising, inflammation of a vein (phlebitis), infection, bleeding discoloration, nausea, vomiting and allergic reaction. I further understand that, in extremely rare instances, damage to the brain or other organ supplied by an artery, and even death, can occur.

To help minimize risks and complications, I have disclosed to the doctor 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. *Females Only: I am not currently pregnant nor is it possible that I am pregnant. If I am unsure of my pregnancy status I have had the opportunity to request a laboratory evaluation of my pregnancy status.*

Alternatives To Suggested Treatment: Alternatives to IV conscious sedation include local anesthesia, oral sedation, intramuscular sedation, and general anesthesia in the hospital or an outpatient surgery center. Local anesthesia and oral sedation may, however, not adequately dispel my fear, anxiety, or stress. If certain medial conditions are present, it may present a greater risk. There may be less control of proper dosage with oral sedation than with IV conscious sedation. General anesthesia will cause me to lose consciousness and generally involves greater risk than IV conscious sedation.

Necessary Follow-up Care And Self-Care: I understand that I must refrain from drinking alcoholic beverages and taking certain medications for a twenty-four (24) hour period following administration of IV conscious sedation. I also understand that a responsible adult should drive me home and remain with me until the effects of the sedation have worn off and that I should not drive a motor vehicle, operate dangerous machinery, handle sharp objects, or make any financial decisions on the day that I receive the sedation.

No Warranty Or 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.

Publication Of Records: I authorize photos, slides, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, without my permission.

I have been fully informed of the nature of IV conscious sedation, the procedure to be utilized, the risks, benefits of this form of sedation, the alternatives available, and the necessity for follow-up. I have had an opportunity to ask any questions I may have in connection with the procedure and to discuss my concerns with the doctor. I hereby consent to the performance of IV conscious sedation as presented to me during consultation and in the treatment plan presentation as described in this document.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

______________________________ ______________

Signature of Patient (or Legal Guardian) Date

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Signature of attending doctor

____

Signature of Witness

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