Dental Solutions
a whole health approach

MONITORED SEDATION INFORMED CONSENT

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 question.

_____ 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. (See #4 options.)

_____ 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 intravenous delivery. 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:

_____ A. (Oral Sedation) Inadequate sedation with initial dosage may require the 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, and other sicknesses.

_____ C. Inability to discuss treatment options with the doctor should circumstance require a change in treatment plan.

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

_____ 7. I have had the opportunity to discuss conscious sedation and have my questions answered by qualified personnel including the doctor. I also understand that I must follow all the recommended treatments and instructions of my doctor.

_____ 8. 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, 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 understand that on rare occasions, and more frequently if I have a known prostate issue(s) and urinary retention, I may have trouble voiding my bladder after sedation. There is a possibility that I may need additional medical treatment outside of Dr. Wall's office to aid in emptying my bladder (catheter).

Companion Name_____

Companion Address_____

Companion Telephone #_____
Cell #_____

_____ 11. I hereby consent to conscious sedation in conjunction with my dental care.

_____
NAME

_____ _____
SIGNATURE Date

_____
Witness

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