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CONSCIOUS SEDATION CONSENT FORM

Name: _____ Appointment Date: _____

The purpose of this document is to provide an opportunity for our 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 the 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 asleep**. The child will be able to respond during the procedure. The child's ability to respond normally returns when the effects of the sedation wear off.

___3. I understand that the conscious sedation will be achieved by the following route:
Oral Administration: The patient will take the medication approximately 15 minutes before the appointment at our clinic. The sedation will last approximately 4 to 8 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. Nitrous oxide sedation: Commonly called laughing gas, nitrous oxide provides relaxation but the patient is still generally aware of surrounding activities. Its effect can be reversed in 5 minutes with oxygen.
___ c. Oral sedation: medication taken orally provides anxiolysis. Patient is sedated but is awake and aware of surroundings.
___ d. General anaesthetic: commonly called deep sedation, a patient under general anaesthetic has no awareness and must have their breathing temporarily supported.

___5. I understand that there are risks or limitations to all procedures. For sedation these include:
___ Inadequate sedation with initial dosage may require the patient to undergo the procedure without full sedation or delay the procedure for another time.
___ Atypical reaction to sedative drugs which may require emergency medical attention and/or hospitalization such as altered mental states, physical reactions, allergic reactions, and other sickness.
___ The most common side effect with oral sedation is drowsiness and vomiting.

___ 6. If, during the procedure, a change in treatment is required, I authorize the dentist and the operative team to make whatever change they deem in their professional judgement 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 dentist.

___ 8. I must notify the dentist if the child has sensitivity to any medication, of the present mental and physical condition

___ 9. I hereby consent to conscious sedation in conjunction with my dental care.

___ 10. I understand the fee for the sedation appointment **is NON-REFUNDABLE and NON-TRANSFERABLE if I choose to cancel or reschedule my appointment with less than one week notice.**

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____