ALASKA AVENUE
DENTAL CLINIC

PROCEDURAL SEDATION INFORMED CONSENT FORM

Patient name:_____ DATE:_____

PROCEDURE(S):

_____

_____

_____

OPERATING DENTIST:_____

I consent to the procedure(s) noted above being performed on me. I acknowledge that the procedure(s), its implications and possible complications have been explained to me, along with the alternatives, including not having any treatment. I understand the procedure will entail moderate IV sedation and I consent to the administration of this sedation by the above-named practitioner. I also understand that during the course of any treatment, unforeseen circumstances may arise that could necessitate or make it advisable for an additional or alternative procedure to be performed, which I also consent to being performed on me.

The purpose of this document is to provide an opportunity for patients to understand and give permission for moderate IV procedural sedation when provided along with dental treatment. Each item should be initialed by the patient, after the patient has the opportunity for discussion and questions.

1. I understand that the purpose of sedation is to more comfortably receive necessary care. Moderate IV procedural sedation is not required to provide the necessary dental care. I understand that moderate IV procedural sedation has limitations and risks and absolute success cannot be guaranteed. Initials:_____

2. I understand that moderate IV procedural sedation is a drug-induced state of reduced awareness and decreased ability to respond. Moderate IV procedural sedation does not produce a state of sleep. I will be able to respond during the procedure. My ability to respond normally returns when the effects of the sedation wear off. Initials:_____

3. I understand that there are risks or limitations to all procedures. For sedation these include:
    a. Inadequate sedation with initial dosage which may require patient to undergo the procedure without full sedation or to have the procedure

another time. An additional dose or doses may be required to complete the procedure. Initials:_____

b. Atypical reaction to sedative drugs that may require emergency medical attention and/or hospitalization such as altered mental states, physical reactions, allergic reactions and other sickness, including respiratory or cardiac arrest. Initials:_____
c. Inability to discuss treatment options with the doctor should circumstance requires a change in treatment plans. Initials:_____

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

5. I have had the opportunity to discuss the 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. Initials:_____

6. 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. Initials:_____

7. I will not be able to drive or operate machinery 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. Initials:_____

8. I acknowledge receiving a copy of the pre- and post-operative instructions, which have been explained to me. I understand all of the advice given to me by my dentist. After my discharge, I will notify my doctor and dentist if I experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems. Initials:_____

Signature:_____ Date:_____

Patient__ Parent__ Legally authorized representative__