Redcliff Family Dental Oral Sedation Consent Form

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 must be initialed by the patient, after the patient has had the opportunity for discussion and questions.

____ 1. I understand that the purpose of conscious sedation is to receive necessary care more comfortably. It is not required to provide the necessary dental care and has limitations and risks and absolute success is not guaranteed.

____ 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 oral administration. **I will be given a prescription pill at Redcliff Family Dental 60 minutes prior to my appointment.** The sedation will last approximately 8 to 24 hours.

____ 4. I understand that the alternatives to conscious sedation are:

a. No sedation: The procedure is performed under local anesthetic with the patient fully aware.
b. Nitrous Oxide Sedation: This drug-induced state of reduced awareness and decreased ability to respond is delivered via inhalation.
c. IV Administration: The sedative is injected into a tube connected to a vein in my arm. A referral to another office is needed.
d. General Anesthetic: Commonly called deep sedation, a patient under general anesthetic has no awareness and must have their breathing temporarily supported. A referral to another office is needed.

____ 5. I understand that there are risks or limitations to all procedures. For sedation these include:

- (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.
- 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 illnesses.
- Inability to discuss treatment options with the doctor should circumstance require a change in treatment.

____ 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 an individual who will make such a decision.

____ 7. I understand that I must notify the doctor if I am pregnant, or 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.

____ 8. 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 appointments.

____ 9. I have had the opportunity to discuss conscious sedation and have my questions answered by qualified personnel including the doctor. I understand that I must follow all the recommended treatments and instructions of my doctor. I hereby consent to conscious sedation in conjunction with my dental care.

____10. I understand I must follow the pre-operative instructions provided, such as I must **fast for a minimum of 6 hours from a light meal and a minimum of 2 hours from clear fluids** before my appointment time. I acknowledge that a **cancellation charge of $150** will apply if violation of the preoperative instructions leads to cancellation of the scheduled treatment and/or if I do not provide 24 hours notice for cancellations/changes.

Patient's Name and Signature	**Date**	**Dentist's Name and Signature**