# Consent for Oral Sedation

**The purpose of this document is to provide an opportunity for patients to understand and give permission for oral sedation when provided along with dental treatment. Please initial each section after reading.**

Transportations Name: _____ Phone Number: _____

_____ I understand that the purpose of oral sedation is to reduce anxiety and fear. It is not necessary or required for treatment I understand that oral sedation has limitations and success is not always achieved.

_____ I understand that oral sedation is a drug-induced state of reduced awareness and decreased ability to respond. I understand that patients are able to respond some during the procedure, but the ability to respond varies patient to patient. I understand my ability to respond normally returns once medications have worn off.

_____ I understand that oral sedation will be achieved by taking the prescribed medication 1 (one) hour prior to my appointment. The sedation generally last 2-6 hours.

_____ I understand that there are alternatives to oral sedation; some of which are not offered at this office:

- No Sedation: The procedure is performed under local anesthetic with the patient fully aware.
- Nitrous Oxide Sedation: Provides relation but the patient is still generally aware of surrounding activities. Effects can be reversed in 5 minutes with oxygen. Offered at this location: **Yes/No**
- Intravenous Sedation: Medications given via an IV usually located in the arm places the patient in a greater depressed level of consciousness.
- General Anesthetic: Support require with breathing through intubation. Patient has no awareness.

_____ I understand that I must personally provide someone who is of legal age and is mentally and physically capable to escort and transport me to and from the appointment and can provide guardianship, post-operative care and monitoring until sedation wears off.

_____ I understand that there are risks or limitations with oral sedation. These include the following:

- Inadequate initial dose may require treatment without sedation or rescheduling appointment for another day.
- Allergic or atypical reaction to drugs, which may require emergency medical attention and/or hospitalization.
- Inability to discuss changes in treatment options with doctor while sedated.

_____ If while I am the effects of oral sedation, an emergency situation arises, I authorize my dentist to treat the emergency as he deems necessary.

_____ If while I am under the effects of oral sedation; a non-urgent, but unexpected finding is made requiring a change in my treatment plan, I authorize that my dentist (check one):

- _____ Discuss my care and treatment with _____ whom I designate to consent/refuse the recommended change in treatment plan on my behalf.
- _____ Not proceed further until I am informed I am informed of and able to understand the reasons for the change in treatment plan and consent to it.

_____ I am not pregnant or lactating.
_____ Any allergies/sensitivities to medications and medications I am currently taking, have been disclosed to the dentist.
_____ I have not recently consumed alcohol.
_____ I have received the pre-operative and post-operative instruction sheet and have had any questions answered to my satisfaction.
_____ I consent to oral sedation with my dental procedure.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____