INFORMED CONSENT FOR IV CONSCIOUS SEDATION

Diagnosis. I have been informed that my treatment can be performed with a variety of types of anesthesia. These include local anesthesia as normally used for minor dental treatment, or local anesthesia supplemented with IV conscious sedation. My periodontist has recommended IV conscious sedation in addition to other possible forms of anesthetic because a long and involved procedure is to be undertaken.

Recommended Treatment: I understand that in IV conscious sedation, small doses of various medications will be administered to produce a state of relaxation, reduced perception of pain, and drowsiness. However, I will not be put to sleep as with a general anesthetic. In addition, local anesthetics will be administered to numb the areas of my mouth to be treated and thus further control pain. I understand that the drugs to be used may include:

_____Versed_____
_____Nubane_____
_____

I recognize that I must do several things in connection with IV conscious sedation. Specifically, I must refrain from eating after midnight the night prior to my dental appointment.

Expected Benefits: The purpose of IV conscious sedation is to lessen the significant and undesirable side affects of long or stressful dental procedures by chemically reducing the fear, apprehension, and stresses sometimes associated with these procedures.

Principal Risks and Complications: I understand that occasionally complications may be associated with IV conscious sedation. These include pain, facial swelling, or bruising, inflammation of a vein (phlebitis), infection, bleeding, discoloration, nausea, vomiting, or allergic reaction. If further understand that, in extremely rare instances, damage to the brain or other organ supplied by an artery, and even death, can occur.

To help minimize risks and complications, I have disclosed to my periodontist any and all drugs and medications that I am taking. I have also disclosed any abnormalities in my current physical status or past medical history. This includes any history of drug or alcohol abuse and any unusual reactions to medications or anesthetics.

Alternative to Suggested Treatment: Alternatives to IV conscious sedation includes local anesthesia, oral sedation, intramuscular sedation, and general anesthesia in the hospital or surgical center. Local anesthesia and oral sedation may, however, not adequately dispel my fear, anxiety, or stress. If certain medical conditions are present, it may present a greater risk. There may be less control of proper dosage with oral sedation than with IV conscious sedation. General anesthesia will cause me to lose consciousness and generally involves greater risk than IV conscious sedation.

Necessary Follow-up Care and Self Care: I understand that I must refrain from drinking alcoholic beverages and taking certain medications for a 24 hour period following the administration of IV conscious sedation. I also understand that a responsible adult should drive me home and remain with me until the effects of the sedation have worn off and that I should not drive or operate dangerous machinery for the remainder of the day on which I receive sedation.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. I recognize that, as noted above, there are risks and potential complications in the administration of IV conscious sedation.

PATIENT CONSENT

I have been fully informed of the nature of IV conscious sedation, the procedure to be utilized, the risks and benefits of sedation, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of IV conscious sedation as presented to me during consultation and in this document.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____ _____

DATE PRINTED NAME OF PATIENT, PARENT, or GUARDIAN

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

_____ _____

DATE PRINTED NAME OF WITNESS

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SIGNATUE OF WITNESS