ADVANCED DENTISTRY

WITH A GENTLE TOUCH

IMPORTANT INFORMATION & INFORMED CONSENT FOR ORAL SUB MUCOSAL and IV SEDATION
(triazolam, diazepam, lorazepam, midazolam, zaleplon, and or hydroxyzine)

Date

Month Day Year

Email

example@example.com

Patient

First Name Last Name

1. Background Information. This form is designed to provide information regarding the use of oral sedation agents (triazolam, diazepam, lorazepam, midazolam, zaleplon, and or hydroxyzine). We have tried to provide the following information about these agents in "plain English" and your cooperation and understanding of this material is necessary as we strive to achieve the best results for you. Sedation of the type produced by these agents has proven to be useful in controlling the fears of many dental patients. The properties of these agents have allowed many patients to receive dental treatment in a safe, relaxed state with a reduction in their level of fear and anxiety. However, your awareness and ability to respond will be decreased. Like all medications, though, there are limitations and risks (which will be discussed below), and absolute success of treatment with oral sedatives is variable and cannot be guaranteed.

Initials

I understand that conscious sedation has limitations and risks and absolute success cannot be guaranteed. I further understand that conscious sedation is a drug-induced state of reduced awareness and decreased ability to respond. My ability to respond normally returns when the effects of the sedative wear off.

2. **Candidates For SEDATION**. We endeavor to determine eligibility for treatment with oral sedatives through information gathered during our consultation and screening. While many individuals will qualify for treatment with sedatives, not all people are candidates for it. If this situation occurs, the doctor will discuss his/her findings with you, perhaps along with certain other possible treatments or options as appropriate. Women who are pregnant, with likelihood to become pregnant, or lactating should not use oral sedatives (as it may cause fetal damage) nor should people with a known sensitivity to the benzodiazepine class of medication. Also, patients should not consume alcohol while taking oral sedatives or increase the prescribed dosage. If you have been taking any psychiatric mood altering drug, have a bowel obstruction, or any acute respiratory conditions such as cold, flu, or sinus infection, you may not be a good candidate for the use of oral sedation. Please notify the doctor if you have any of these conditions to discuss other options that may be available.

Initials

I understand that I must notify the doctor if I am pregnant, may be pregnant, or if I am lactating. I must notify the doctor if I have sensitivity to benzodiazepines, if I have recently consumed alcohol, and if I am on psychiatric mood altering drugs or other medications. _____

3. **Your Protocol For The Administration of SEDATION**. You will not be allowed to drive to or from your appointment and you must have someone pick you up, remain in the office, and accompany you home following your treatment with oral sedation. This person must be 19 years or older. Due to a possible amnesia effect, you should also arrange to have a trusted friend or loved one with you in the 24 hours after your treatment.

Signature

I understand the prescribed protocol that will be used during my (par) enteral conscious sedation. It is essential to have another person accompany me to my visit to provide for my transportation and care. _____

4. **Alternative Options**. Please note that there are other sedation options available for your procedure including nitrous oxide, which is relaxation gas known as laughing gas, topical anesthetic, which is a numbing gel that can be placed in your mouth and give you more comfort., These and other methods can often be a valid alternative to enteral or par enteral conscious sedation. Other alternatives are to have no treatment performed or no pain medications or sedative agents used. If you have any questions regarding any treatment alternatives, please ask your treating dentist or your treatment consultant. I understand and have been informed of my possible alternative options to (par) enteral conscious sedation.

Initials

I understand the prescribed protocol that will be used during my (par) enteral conscious sedation. It is essential to have another person accompany me to my visit to provide for my transportation and care _____

5. Risks & Inconveniences Virtually all forms of medication, including oral sedatives, have some risks and possible side effects. Pain medication or sedative agents can, among other things, alter your judgment and work performance, and you should plan accordingly. With sedation, you may experience relaxation or drowsiness, a reduced sense of fear or anxiety, increased tolerance to discomfort, an altered perception of time, tingling sensations, giddiness or lightheadedness, clumsiness, or unsteadiness, nausea, hallucinations or dreams.Less common side effects include blurred vision, memory loss (which many people deem desirable for dental treatment), or "rebound insomnia"' for several days. Rare side effects include agitation, behavior changes, convulsions, hypotension, skin rash or itching, sore throat, fever, chills, unusual tiredness, increased heart rate, hyperactivity or weakness may occur. If you experience any unpleasant affects, before or after your procedure, please inform the doctor or assistant as soon as possible. There is also a chance of an allergic reaction to the sedation medication which may include: itching, hives, redness of the skin, swelling or sweating. If you notice any of the symptoms you must contact your dentist or other medical professionals immediately.

Initials

I understand the risks and inconveniences that may result from enteral conscious sedation and these have been thoroughly explained to me. _____

6. **Other Patient Responsibilities**. You agree to keep your follow-up appointments and to follow recommended treatments as well as follow other precautions and recommendations that may be provided as part of your pre-op or post-operative instructions. You will not be able to drive or operate machinery while taking oral sedatives and for 24 hours afterwards. Therefore, you will need to have arrangements for someone to drive you to and from your dental appointments while taking oral sedatives.

Initials

I understand that I must follow all the recommended treatments and instructions of my doctor. I also understand the possible affects that sedatives will have on me following (par) enteral conscious sedation. _____

7. **PATIENT QUESTIONS**. The patient has the right to be completely informed before they give their consent to a procedure. If you have any questions about the enteral conscious sedation, about this form, or any other topic, be sure to discuss this with your treating dentist prior to beginning treatment.

Initials

I understand that I have the right to question any portion of my treatment and to have a thorough and complete explanation to any question I may have from a qualified person. _____

8. **UNFORSEEN CIRCUMSTANCES**. You may also want to designate in writing a person to make any needed decision regarding your treatment or additional treatment or declining treatment while you are in a sedated state. If you do not designate such a person, you authorize the dental practice doctors to use their professional judgment in making decisions regarding your treatment as the circumstances warrant in fulfilling the health-related, functional and aesthetic objectives set out in your treatment plan and clinical records.

Initials

I understand that unforeseen circumstances may arise that may necessitate a decision being made on my behalf. I have the right to designate the individual who will make such a decision. _____

Name of designated person

CONSENT

I acknowledge that Robert Korwin, D.M.D. and associates has explained to me in general terms sedation, the alternatives (including non-use) and the risks and inconveniences. I am aware of the conditions that may preclude the use of oral sedation and confirm that I do not fall into any of these conditions or categories. I have been given the opportunity to ask any questions and any such questions have been answered or explained to my satisfaction. I authorize Robert Korwin, D.M.D. and associates to use his professional judgment to manage any conditions that might unexpectedly arise during the course of the procedure. By signing below, I acknowledge that I have been given time to read and have read the preceding information in this document. I understand this form and I consent to the administration of oral sedation.

Patient Signature _____

Date

Month Day Year

PATIENT'S AUTHORIZED REPRESENTATIVE

(If patient is under 18 years of age or you are consenting to the care of another)

I have the legal authority to sign this consent on behalf of: Minor Patients Name

First Name Last Name

Date

Month Day Year

Signature

Your Relationship to Patient:

PATIENT'S DESIGNATED DRIVER AND COMPANION

Please designate below the name and telephone numbers for your designated driver (who must be over 19 years of age):

Name of Driver:

First Name Last Name

License Number and State

Primary Phone Number:

Area Code Phone Number

Secondary Phone Number:

Area Code Phone Number

I understand that I will have to be continuously available during and after the appointment time and understand my responsibility before, during, and after the appointment.

Signature of designated driver and responsible companion.