Newark Smiles Conscious Sedation Informed Consent

Dr. Shayer Shah, D.D.S.

The purpose of this document is to provide an opportunity for patients to understand and give permission for conscious sedation when provided along with dental treatment. Each item should be checked off after the patient has the opportunity for discussion and questions.

_____ 1. I understand that the purpose of conscious sedation is to more comfortably receive necessary care. Conscious sedation is not required to provide necessary dental care. I understand that conscious sedation has limitations and risks and absolute success cannot be guaranteed. (see #4 options)

_____ 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 the following route: **Oral Administration**: I will take one pill, as prescribed at bedtime the night before my appointment and I will take one pill one hour before my appointment and I will bring one pill with me to my appointment. The sedation will last approximately 4 to 6 hours.

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

_____ a. No Sedation: The necessary procedure under local anesthetic with the patient fully aware
_____ b. Anxiolysis: Taking a pill to reduce fear and anxiety
_____ c. Nitrous Oxide Sedation: Commonly called laughing gas, nitrous oxide provides relaxation but the patient is still generally aware of surrounding activities. Its effects can be reversed in five minutes with oxygen

_____ d. IV Conscious Sedation

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

_____ A typical reaction to sedative drugs which may require emergency medical attention and/or hospitalization such as altered mental states, physical reaction, allergic and other sickness

_____ Inability to discuss treatment options with the doctor should circumstance require a change in treatment plan

_____ 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 the individual who will make such a decision.

_____ 7. I have had the opportunity to discuss conscious 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.

_____ 8. 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 a psychiatric mood altering drug or other medications.

_____ 9. 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 appointment while taking oral sedatives.

Patient/Guardian Signature **Date**

Witness

Newark Smiles IV Sedation Pre-Op Questionnaire for Office Anesthesia

Name ____ Age ________________

Birthdate: ____/ ____/____ Weight ____________ Sex M F

Do you have any of the following (past or present): Circle NO or YES, if yes, please explain.

Smoking/Nicotine Use	No	Yes: ___________________________________
Medications	No	Yes: ___________________________________
		___________________________________
		___________________________________
		___________________________________
Allergies	No	Yes: ___________________________________
Bleeding Tendencies	No	Yes: ___________________________________
Snoring	No	Yes: ___________________________________
Sleep Apnea	No	Yes: ___________________________________
High Blood Pressure	No	Yes: ___________________________________
Diabetes	No	Yes: ___________________________________
GERD (Heartburn, Acid Reflux)	No	Yes: ___________________________________
Sinus Drainage of Allergy Symptom	No	Yes: ___________________________________
Stroke, TIA, Seizures, Head Injury	No	Yes: ___________________________________
Fainting, Dizzy Spells	No	Yes: ___________________________________
Mental Handicaps or Autism	No	Yes: ___________________________________
Pregnant or any possibility of pregnancy	No	Yes: ___________________________________
Hepatitis or Liver Disease	No	Yes: ___________________________________
Blood Disorders (Anemia, etc)	No	Yes: ___________________________________
Stomach Ulcers	No	Yes: ___________________________________
Herpes	No	Yes: ___________________________________
HIV	No	Yes: ___________________________________
Tuberculosis (TB)	No	Yes: ___________________________________
Glaucoma	No	Yes: ___________________________________
Arthritis	No	Yes: ___________________________________
Heart Disease (angina, heart attack, heart surgery, cardiologist, EKG history, cardiac tests, ect)	No	Yes: ___________________________________
Breathing Difficulties (lung disease, asthma, Reactive Airway Disease, COPD, Emphysema, shortness of breath, sleep with head raised with more than 1 pillow, chronic bronchitis, ect)	No	Yes: ___________________________________
Family History of Anesthesia Problems	No	Yes: ___________________________________

Previous Surgeries and Anesthesia History: ____
____
____

Any other medical issues not listed? No Yes: ___________________________________

I have listed all my medications, reactions and medical history.

Patient Signature **Date**

1619 W. Main Street Newark, OH 43055 | (740) 522-1133 | www.newarksmiles.com

Newark Smiles Medical Fax Back

Date ________________

Dear Dr. ____, (Fax # __________________________).

Our shared patient, __________________________________ has chosen to proceed with their dental care while using oral conscious sedation or IV sedation.

Please review the attached medical history the patient has provided to our office and let us know if there would be any conditions not listed that would prevent us from providing them with sedation dentistry. The patient is scheduled for sedation in our office on: ________________________________.

We will be using the following medications: (oral conscious sedation)

_____ Triaxolam (0.25mg) (Halcion) – 1 (one) 1 hour prior to sedation appointment

_____ Triazolam (0.25mg) (Halcion) – 1 (one) before bedtime the night before appointment

_____ Diazepam (5mg) (Valium) – 2 (two) 1 hour before bedtime the night before appointment

_____ Hydroxyzine (Vistarill) – used during appointment for nicotine users

_____ Lorazepam (Ativan) – used during appointment for longer sedations

Intravenous Sedation:

_____ Midazolam (Versed)

_____ Fentanyl

_____ Diazepam (Valium)

Sincerely,

Shayer Shah, D.D.S.

Please fax this letter back to us indicating your medical opinion if they have any health concerns that would prevent them from having the sedation medication along with any other comments or concerns you may have. Thank you for your prompt attention to this matter.

Signature

Approve ________________ Disapprove ________________

Comments ____
____
____
____
____
____
____

Please Fax Back to Dr. Shah at 740.522.1178