INFORMED CONSENT

# Sedation and Analgesia

Intravenous, oral, and inhalation

*Please read this form carefully and ask us about anything that is unclear before you sign.*

PATIENT NAME _____ DATE OF BIRTH _____

SEDATION PROVIDER _____ DATE OF PROCEDURE _____

## 1 Recommended Treatment

I give my consent to the sedation provider named above, and to the team working under that provider's direction, to administer the following sedation or analgesia to me or my dependent for the planned dental procedure(s) (the "Recommended Treatment"):

- ☐ Intravenous (IV) sedation
- ☐ Oral sedation
- ☐ Inhalation analgesia (nitrous oxide / oxygen)
- ☐ Other:_____

I understand that the depth of sedation can vary, and that I may become more deeply — or less deeply — sedated than planned. My heart rate, blood pressure, oxygen level, and breathing will be monitored during the procedure, and the team is prepared to respond to emergencies.

I consent to placement of an IV line, to the use of additional or emergency medications and airway support, and — if the doctor considers it necessary for my safety — to calling emergency medical services (911) and transfer to a hospital. I also consent to any additional procedure(s) considered necessary for my well-being based on findings made during the course of the Recommended Treatment, and to the administration of local anesthesia.

The nature and purpose of the Recommended Treatment have been explained to me, and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed.

## 2 Treatment Alternatives

Alternative methods of treatment have been explained to me, including the following (doctor to check those discussed):

- ☐ **Local anesthesia alone** (numbing only), without sedation
- ☐ **Lighter sedation** — nitrous oxide / oxygen or oral sedation
- ☐ **Treatment in shorter or staged visits**
- ☐ **Treatment in a hospital or surgery center** under general anesthesia (a different setting from this office)
- ☐ **Postponing or declining treatment**
- ☐ Other:_____

Having considered these alternatives, I wish to proceed with the Recommended Treatment described above.

## 3 Before My Procedure

### Please read and follow these instructions

- **Fasting (NPO) — at least 8 hours.** I must have nothing to eat or drink, including water, gum, and mints, for at least 8 hours before my appointment. The only exception is medication the doctor has told me to take with a small sip of water. If I have had anything by mouth inside this time, I must tell the doctor before sedation begins; sedation will not be given and the procedure will be rescheduled.
- **Responsible adult.** A responsible adult (18 or older) must bring me, take me home, and stay with me for the rest of the day and night after the procedure.
- **Tell the doctor** if I am or may be pregnant; about all prescription and over-the-counter medications, supplements, alcohol, cannabis, and other substances I use; about my allergies; about any recent illness, cold, or fever; and about any problem I or a blood relative has had with anesthesia.
- **Clothing.** Wear loose, comfortable clothing with short sleeves, leave jewelry at home, and remove contact lenses.
- **For at least 24 hours** after sedation I will not drive, operate machinery or power tools, drink alcohol, take sedating drugs the doctor has not approved, sign legal documents, or make important decisions.

#### DAY-OF-PROCEDURE CONFIRMATION (COMPLETED WITH THE TEAM ON ARRIVAL)

**Last food or drink (date / time):** _____

**Responsible adult — name and phone:** _____

☐ Team has confirmed fasting of at least 8 hours (initials: ____)

## 4 Risks and Potential Complications

I understand that there are risks and potential complications associated with the administration of medications, including anesthesia, and with performance of the Recommended Treatment. These include, but are not limited to, the following:

### RISKS OF ANESTHESIA AND SEDATION

1. **Drug reactions and side effects,** including allergic reactions ranging from rash and swelling to severe allergic reaction (anaphylaxis).
2. **Injection and IV-site problems.** Pain, redness, swelling, reduced function, bruising, and/or bleeding at the injection site(s), including inflammation of the vein (phlebitis) or a collection of blood (hematoma). This is usually temporary but may be more long-lasting.
3. **Nausea and vomiting.**
4. **Drowsiness, dizziness, and impaired judgment or memory** that may last for hours after the procedure, with a risk of falls.
5. **Breathing problems.** Slowed or stopped breathing, low blood oxygen, airway blockage, or spasm of the vocal cords (laryngospasm), which may require airway support such as a mask, a breathing tube, or emergency medications.
6. **Aspiration.** Stomach contents or fluid may enter the lungs and cause pneumonia or lung injury. This risk is higher if I have not fasted as instructed.
7. **Heart and blood pressure effects.** Low or high blood pressure, slow, fast, or irregular heartbeat, heart attack, or stroke.
8. **Airway-related injury.** Sore throat, hoarseness, or cough, and rarely injury to the lips, teeth, tongue, or throat during airway support.
9. **Unexpected reactions.** Agitation, confusion, or hallucination as the medicine wears off; being more awake than planned, with possible awareness or recall of parts of the procedure; or needing the procedure to be stopped or rescheduled.
10. **Nerve injury.** Possible injury to nerves at the injection site(s), resulting in temporary or permanent tingling, numbness, or pain (possibly of an electric-shock nature) of the areas at or near where the injection was given.
11. **Drug interactions.** Medications, herbal supplements, alcohol, cannabis, or other substances may interact with anesthesia and increase these risks.
12. **Emergency transfer.** If a serious problem occurs, I may need emergency transfer to a hospital and hospital admission.
13. **Severe, irreversible injury, including brain damage, cardiac arrest, and death.**

## 5 After My Procedure

- I will stay in the office until the doctor decides I have recovered enough to leave, and I will receive written instructions.
- I may feel drowsy, dizzy, or forgetful for several hours. I will rest, stay with my responsible adult, and avoid activities that need balance or alertness.
- I will resume fluids and light food as instructed once any nausea has passed.
- I will contact the office if I am **unable to urinate within 6 hours of the procedure**, or for persistent vomiting, fever, or other concerns. For trouble breathing, chest pain, or any emergency, I will call 911.

## 6 Patient Acknowledgment

By signing below, I confirm that:

- The nature and purpose of the Recommended Treatment, its expected benefits and risks, and the alternatives — including no treatment — have been explained to me in terms I understand.
- I have had the opportunity to ask questions, and they have been answered to my satisfaction.
- The health history, medication, and allergy information I have given this office is complete and accurate, and I will report any change before treatment.
- I have read and understand the pre-procedure instructions in this form and will follow them. I understand the doctor may postpone or cancel the procedure if I do not, or if my health has changed.
- I understand that the risks listed in this form are not a complete list, that no guarantee has been made about the result, and that additional or different treatment may be needed.
- I understand that I may ask questions, or withdraw my consent, at any time before treatment begins.
- I have been offered a copy of this signed form.

**I consent to the Recommended Treatment described in this form.**

## 7 Signatures

☐ Interpreter or language assistance used — name / ID:_____

_____ _____

Patient / parent / legal guardian signature | Date and time

_____ _____

Printed name | Relationship to patient (if signer is not the patient)

_____ _____

Witness signature | Witness printed name

**Doctor's statement.** I have discussed the nature, purpose, benefits, risks, and alternatives of the Recommended Treatment with the patient (or the patient's legal representative), have answered their questions, and believe they understand and consent.

_____ _____

Treating doctor signature | Date and time