Pacific One Dental

102 – 5160 Dublin Way,
Nanaimo, BC V9T 0H2

250-585-2185

PROCEDURAL SEDATION INFORMED CONSENT FORM

Patient name: _____ Date: _____

Preferred name: _____

Procedures: _____

Operating Dentist: _____

I consent to the procedure(s) noted above being performed on me. i acknowledge that the procedure(s), its implications, and possible complications have been explained to me, along with the alternatives, including not having any treatment. I understand the procedure will entail moderate IV sedation and I consent to the administration of this sedation by the above-named practitioner. I also understand that during the course of any treatment, unforeseen circumstances may arise that could necessitate or make it advisable for an additional or alternative procedure to be performed, which I also consent to being performed on me.

The purpose of this document is to provide an opportunity for patients to understand and give permission for moderate IV procedural 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 sedation is to receive necessary care more comfortably. Moderate IV procedural sedation is not required to provide the necessary dental care. I understand that moderate IV procedural sedation has limitations and risks, and absolute success cannot be guaranteed. Initials: _____

2. I understand that moderate IV procedural sedation is a drug-induced state of reduced awareness and decreased ability to respond. Moderate IV procedural sedation does not produce a state of sleep. I will be able to respond during the procedure. My ability to respond normally returns when the effects of the sedation wear off. Initials: _____

3. I understand that there are risks or limitations to all procedures. For sedation these include:
   a. Inadequate sedation with initial dosage which may require patient to undergo the procedure without full sedation or to have the procedure another time. An additional dose or doses may be required to complete the procedure. Initials: _____
   b. Atypical reaction to sedative drugs that may require emergency medical attention and/or hospitalization such as altered mental states, physical reactions, allergic reactions and other sicknesses, including respiratory or cardiac arrest. Initials: _____
   c. Inability to discuss treatment options with the doctor should circumstance requires a change in treatment plans. Initials: _____

4. 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. Initials: _____

5. I have had the opportunity to discuss the 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. Initials: _____

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6. 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 psychiatric mood-altering drugs or other medications. Initials: _____

7. I will not be able to drive or operate machinery for 24hours after my procedure. I understand I will need to have arrangements for someone to drive me to and from my dental appointment. Initials: _____

8. I acknowledge receiving a copy of the pre- and post-operative instructions, which have been explained to me. I understand all the advice given to me by my dentist. After my discharge, I will notify my doctor and dentist if I experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems. Initials: _____

Signature _____

Date _____

Patient ☐ Parent ☐ Legally Authorized Representative ☐

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PHYSICAL EXAMINATION

Patient name: | DOB (M/D/Y):

Patient no.: | Date:

Neck Mobility Issues: (have patient touch chin to chest and then look straight up at ceiling)

1. Mallampaii Score: Class: _____
2. Respiratory Assessment
   a. Air Entry/Adventitious Sounds (listen only if needed: COPD, CHF, Asthma):
   b. Other Findings:
3. Body Mass Index: _____ Weight: _____ Height. _____
4. ASA Score: _____
5. Vascular Access Assessment: Pass / Difficult (Have a look to see if veins easy to see, use a BP cuff or tourniquet as needed)
6. Baseline Screening Vitals (To be placed on Anaesthesia Record)
   a. BP: _____
   b. O2 saturation: _____
   c. HR: _____
   d. Respiratory rate: _____
7. Preoperative Instructions Given: _____

Notes:

Assessor: _____

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POST-SEDATION PATIENT INSTRUCTIONS

Following sedation, 24 hours may be required for the full effects of the drugs to wear off.
During this period, it is essential that you follow these instructions.

DISCHARGE FROM OFFICE

- The patient must be discharged into the core of a responsible adult who can accompany him/her home
- Arrangements should be made to have a responsible adult remain with the patient for the balance of the day/night if drowsiness persists

TRANSPORTATION FROM OFFICE

- Private automobile is preferred

FOOD AND BEVERAGES

- Clear liquids are advised initially, after that, diet as tolerated
- Specific instructions regarding your dentistry may be given
- Do not drink alcohol in any form for 24 hours

MEDICATIONS

- Resume normal medication as directed by your dentist after appointment.

ACTIVITY RESTRICTIONS

- **Do not operate motor vehicles, boats, power tools or machinery for 24 hours, or longer If drowsiness or dizziness persists**
- Do not operate an aircraft for at least 48 hours following minimal or moderate sedation
- Do not sign or enter into any legal contract for at least 24 hours

PROBLEMS

- If you experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problem of concern please see your regular dentist or your family doctor or go to the closest emergency department.
  Call **Pacific One Dental** at **250-585-2185** if you which to speak to our office.

OTHER INSTRUCTIONS

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POST-SEDATION PATIENT INSTRUCTIONS

For the safe treatment of the patient, the following pre-sedation instructions must be followed very carefully.

FOOD AND BEVERAGES

- Nothing to eat or drink for 8 hours prior to dental procedure with the exception of water and clear fluids (Apple juice, tea, coffee, or water, but not alcohol).
- Stop drinking clear fluids for 2 hours prior to dental procedure.

MEDICATIONS

- It is essential to discuss with your dentist whether or not you should take medication(s) you otherwise take on a regular basis.

CLOTHING

- Remove nail polish from at least one fingernail on each hand
- Wear loose casual clothing for your appointment (e.g., short sleeve t-shirt).
- Female patients should wear slacks.
- Best to leave jewelry at home

SMOKING

- Refrain from smoking prior to treatment.

TRANSPORTATION

- Under no conditions can you drive yourself home. A responsible adult (excluding a taxicab driver) must accompany you home. A taxi driver or similar service does not count as your escort.

CHANGE IN HEALTH STATUS

If your general health deteriorates (e.g., cold, cough, fever, etc.) contact

Pacific One Dental at **250-585-2185** prior to the day of the appointment.

If in doubt, please phone to report the change in your health status.

If you have any questions, please do not hesitate to ask them. It is important that you understand the circumstances surrounding this treatment.

Please arrive 15 minutes before your assigned appointment time.