NORTH WOODSTOCK DENTISTRY

870 Queenston Blvd
Woodstock, ON N4T 0M4
T: 519 537 3444
F: 519 537 2134
E: info@woodstockdentist.ca

ADULT ORAL SEDATION INSTRUCTIONS AND CONSENT

PATIENT NAME: _____ DATE: _____

ATTENTING DENTIST: _____

Oral sedation utilizes the elective administration of an oral sedative medication during dental procedures to reduce the fear and anxiety related to the experience. The purpose of this document is to ensure that you understand oral sedation and consent to its use during your dental treatment.

One of our most important policies is to "inform before we perform." Before we begin treatment, we ask your permission for periodic dental examinations, x-rays, dental cleanings and fluoride applications. We also need your permission to perform dental treatments, restorations and/or appliances as needed to return all teeth to health and proper function, using local anesthetic and a comfortable mouth prop. The purpose of all these procedures is to gain and maintain dental health, and we expect good results, although no guarantees as to the results may be given.

Although our goal is for the best oral health, there are some slight risks involved in getting to that goal. Very rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling and infection. But ignoring a known dental problem has an even greater risk. Not treating existing dental problems may result in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

Oral sedation is a valuable modality that can benefit patients when it is determined that chairside manner alone is insufficient. It will make your dental treatment a very pleasant experience. It is

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suitable for most people, but if you are not in good health or taking medication, please tell us so the sedation can be modified to suit your needs.

Please read each page carefully after you have had the opportunity to discuss it with your attending Dentist, and your questions and concerns, if any, have been answered to your satisfaction.

INSTRUCTIONS FOR ADULT ORAL SEDATION

Prior to your appointment, you must plan your day so that the following instructions can be observed:

1. We require you to be present in the office one (1) hour before your appointment time so we can provide you with the medication.

2. DO NOT EAT OR DRINK for eight (8) hours before your appointment. This includes water and all other liquids. Your treatment will be cancelled if you have taken anything by mouth.

3. Notify us of any changes to your health, including all personal illness or allergies, no matter how insignificant they may seem to you, as well as any medication you have taken within the last three weeks.

4. If your regular medication time falls during your appointment, please take it after the treatment. Please discuss with your attending Dentist prior to as well.

5. A responsible family member must arrive with you, stay in the clinic during the procedure, and take you home to your door after the procedure. It is not safe for you to travel home alone or by public transportation/taxi.

6. Make a trip to the washroom prior to your appointment.

7. Do not wear facial make up and nail polish.

8. Remove contact lenses.

9. Wear loose clothing, including short sleeves as monitors will be placed on your fingers and arm before the procedure. Low heeled shoes are recommended. No skirts, dresses and fitted clothing.

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10. Refrain from consuming any alcoholic beverages 24 hours prior to your appointment. No alcoholic beverages should be consumed while taking pain medications operatively.

After your treatment, please ensure that you:

1. Do not drive a car, operate hazardous machinery or appliances post treatment for 24 hours as your hand and eye coordination will be impaired.

2. Should not be left alone to care for small children for 24 hours.

3. Defer any responsible/complicated task(s) or decisions requiring fine judgment for 24 hours.

4. Refrain from drinking any alcoholic beverages for 24 hours after your appointment. No alcoholic beverages should be consumed while taking pain medications operatively.

5. You should refrain from smoking for a minimum of at least four (4) days after the treatment.

6. Some patients become nauseated and some even vomit after receiving the medications. If this occurs, limit your diet to a bland liquid diet for a day or so until the nausea subsides.

*Do not feel alarmed if you are sluggish or disoriented for one or two days after the procedure. This is quite reasonable and expected.

We require one week's notice for scheduling changes. Less than one week's notice will result in a cancellation fee.

I have carefully read and understand the information above.

PATIENT SIGNATURE: _____ DATE: _____

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Please read the information below carefully. Each item must be checked off after the patient has had the opportunity to thoroughly understand all of the information.

1._____ I understand that the purpose of oral sedation is to more comfortably receive necessary care. I understand that oral sedation has limitations and risks and absolute success cannot be guaranteed.

2._____ I understand that oral sedation is a drug induced state of reduced awareness and decreased ability to respond. It 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 treatment will be achieved by oral administration.

4._____ I understand that there are risks or limitations to all procedures. For sedation, these include but, are not limited to;

A._____ Inadequate sedation with initial dosage may require that the patient undergo the procedure without full sedation or delay the procedure for another time.

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

C._____ 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 operative team to make changes they deem in their professional judgment is necessary. I understand that I have the right to designate an individual who will make such decisions.

7._____I have had the opportunity to discuss oral sedation and have had my questions answered by qualified personnel including the Dentist. I also understand that I must follow all of the recommended treatments and instructions of my Dentist.

8._____I understand that I must notify the Dentist if I am pregnant, or if I am lactating. I must notify the Dentist of any sensitivity to any medications, of my present mental and physical condition, if I have recently consumed alcohol, taken any drugs and/or medication and if I am presently on psychiatric mood altering drugs or other medications.

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CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

I, _____, give my consent to the use of local anesthetics and sedative drugs that the attending Dentist may deem necessary or advisable so as to enable him or her to render necessary dental treatment as indicated on the examination chart, as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned treatment, with the exception of:

(if none, so state.)_____

I acknowledge receipt of this document and all the information included.

I understand that occasionally there are complications of the treatment drugs or anesthetic agents; including but not limited to: numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, stroke or heart attack, or disfiguring scars associated with such procedures. I further understand and accept that complications may require hospitalization and further treatment/procedures. I also understand that all of the above, except allergic reaction, may also occur if no treatment is given to the patient.

The attending Dentist has discussed with me, to my satisfaction, these complications. I acknowledge the receipt of and understand the preoperative and postoperative instructions. The treatment and sedation and/or anesthesia procedures have been explained to me, to my satisfaction, along with possible alternative methods and their advantages and disadvantages, risks, consequences and probable effectiveness of each as well as the prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantees as expressed or implied either as to the result of the treatment or as to cure.

I hereby state that I have read and understand this consent, and that all questions about the procedure or procedures have been answered in a satisfactory manner.

Date: _____/_____/_____ Time: _____ am/pm

Signature of Patient: _____

Print Name: _____