

ALL WEST DENTAL
380-3300
ANXIOLYSIS / CONSCIOUS SEDATION CONSENT FORM

The purpose of this document is to provide an opportunity for our patients to understand and give permission for Anxiolysis / Conscious Sedation when provided along with dental treatment. I have discussed with my Dentist each type of sedation and have chosen ANXIOLYSIS or CONSCIOUS SEDATION for my procedure. Each item should be initialed after the patient has the opportunity for discussion and questions.

- x _____ 1. I understand that the purpose of sedation is to more comfortably receive necessary care. I understand that conscious sedation has limitations and risks and absolute success cannot be guaranteed.
- x _____ 2. I understand that 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.
- x _____ 3. I understand that my sedation will be achieved by the following route:
x _____ **Oral Administration:** I will take a pill approximately _____ minutes before my appointment. The sedation will last approximately _____ to _____ hours.
- x _____ 4. I understand that the alternatives to conscious sedation are:
x _____ a) **No Sedation:** The necessary procedure is performed under local anesthetic with the patient fully aware.
x _____ b) **Anxiolysis:** Taking a pill to reduce fear and anxiety

x _____ 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 5 minutes with oxygen.
x _____ d) **Intravenous Administration:** The doctor could inject the sedative in a tube connected to a vein in my arm.
x _____ e) **General Anesthetic:** Commonly called deep sedation, a patient under general anesthetic has not awareness and must have their breathing temporarily supported. General Anesthesia is more appropriate for longer procedures lasting more than 3 hours.
- x _____ 5. I understand that there are risks or limitations to all procedures. For sedation these include:
x _____ a) (Oral Sedation) Inadequate sedation with initial dosage may require the patient to undergo the procedure without full sedation or delay the procedure for another time.
x _____ b) Atypical 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.
x _____ c) Inability to discuss treatment options with the doctor should circumstances require a change in treatment plan.
- x _____ 6. If, during the procedure, a change in treatment plan is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment necessary. I understand that I have the right to designate the individual who will make such a decision.
- x _____ 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.

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- x _____ 8. I understand that I must notify my 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.
- x _____ 9a. I understand that if I choose **Conscious Sedation** I must have someone transport me to and from my appointment. I will not be able to drive or operate machinery while taking oral sedatives for 24 hours after my procedure.
- x _____ 9b. I understand that if I choose **Anxiolysis** I may need to have arrangements made for someone to transport me to and from my dental appointment. Even if I am able to drive to the appointment myself, I may need transport home from my appointment.
- x _____ 10. I hereby consent to Anxiolysis / Conscious Sedation in conjunction with my dental care.
*(circle one)

Patient / Guardian

Date

Witness