INFORMED CONSENT FORM: ORAL MODERATE SEDATION

The purpose of this document is to provide an opportunity for the child's **legally responsible parent/guardian** to understand and give permission for oral moderate sedation of the child in conjunction with his/her dental treatment. The parent/guardian should initial each item after an opportunity for discussion and ask questions.

_____ 1. I understand that the **purpose** oral moderate sedation is to achieve moderate sedation facilitating my child to receive necessary care more comfortably. Moderate sedation is not required to provide the necessary dental care. I understand that moderate sedation has limitations and risks and **absolute success cannot be guaranteed**. (See #4 for alternative options.)

_____ 2. I understand that moderate sedation is a drug-induced state of reduced awareness and decreased ability to respond. The **goal** of moderate sedation is not sleep, however my child may be relaxed enough to fall asleep. His/her ability to respond normally will return when the effects of the sedative(s) wear off.

_____ 3. I understand that the medication for my child's sedation will be administered via the following route: Oral Administration. My child will take the medication at the beginning of the appointment. **Oral moderate sedation is not recommended if your child is not willing to take the medication.** Nitrous oxide, commonly called "laughing gas" may be used in conjunction during the treatment. The effect of sedation may last from 3 up to 24 hours.

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

A. No treatment: Existing condition(s) can worsen. Adverse consequences of no treatment may include but not limited to pain, infection, swelling, deterioration of the bone around the teeth, changes in bite, jaw discomfort, premature lost of teeth and space, emergency medical attention and/or hospitalization.

B. No sedation: Treatment is performed under local anesthetic with the patient fully aware.

C. Nitrous oxide sedation: Commonly called "laughing gas." It provides relaxation if patient is willing and able to breath in the gas. Possible risks include nausea, vomiting, and GI discomfort.

D. Deep sedation/general anesthesia: A controlled state of unconsciousness that requires the services of an anesthesia professional (Please ask for more information).

_____ 5. I understand that there are **risks** or **limitations** to all procedures. For minimal/moderate sedation the possible risks or limitations include:

A. Inadequate sedation and/or paroxysmal reaction (sudden outburst of emotion) may necessitate the patient to complete the procedure without effective sedation, re-schedule the procedure for another time, and/or choose an alternative form of sedation.

B. Deeper-than-anticipated sedation may require premature termination of treatment, administering reversal agent to reduce sedation, prolonging appointment time for observation, and other measures necessary to ensure my child's well being.

C. Possible **complications** of sedative drugs include but not limited to dizziness, sweating, dry mouth, nausea/vomiting, GI discomfort, allergic reaction, seizures, and respiratory depression.

D. Atypical reactions to sedative drugs, which may require emergency medical attention, result in hospitalization, and may even result in death.

_____ 6. I understand that I **must notify** the doctor about all of my child's mental and physical condition, including any allergy or sensitivity to any medications, and if he/she is presently on any medications.

_____ 7. I understand that, to ensure a safe sedation procedure, I must be **present** in the office during the entire sedation procedure. If, during the procedure, a change in treatment is required, I will be asked to make a treatment decision for my child in a timely manner.

_____ 8. I confirm the receipt of and understand the before, during, and after **Sedation Instructions**.

_____ 9. I have had the opportunity to discuss oral moderate sedation of my child, 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 for the best care of my child.

_____ 10. I understand that, every reasonable effort will be made to ensure that the oral moderate sedation procedure is completed safely and efficiently, although it is **not possible to guarantee results**.

_____ 11. I understand that the **sedation fee** is required to reserve the appointment. This fee may not be refunded if you missed the appointment or failed to follow the requirements described in the provided Sedation Instructions. In case of an unsuccessful sedation attempt, reasonable partial refund may or may not be credited back to your account.

Your Child's (Patient's) name: _____ Chart#: _____

I am the legally responsible parent/guardian, and…
I here by (_____)**consent** to oral conscious sedation of my child in conjunction with his/her dental care.
I (_____) **decline** the recommendation of oral conscious sedation for my child in conjunction with his/her dental care.

_____	X_____	____/____/_____	[_____]
Print your name	Signature	Date	Witness