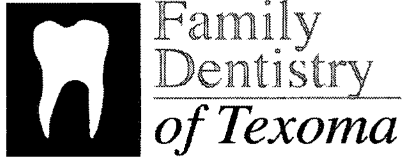


Consent for Intravenous Sedation Analgesia/Anesthesia

Patient: ____ Date: ______________________________

I, ______________________________________ give my consent for Dr. Matt Pitts, D.D.S., along with his staff, to perform the following treatment/procedure/surgery/anesthesia: ______________________________________

Initial each statement after reading. If you have any questions, please ask your doctor before initialing.

Intravenous sedation analgesia/anesthesia is a technique that uses intravenous agents and sometimes nitrous oxide to help relax a patient. You have chosen intravenous sedation analgesia/anesthesia for your dental procedure, a common procedure which is considered quite safe. Nevertheless, any anesthesia carries some risk and the common ones known for intravenous anesthesia are noted below for your review before you consent to its use:

__________1. Previously unknown allergic reactions can occur to any of the medications used.

__________2. Discomfort, swelling or bruising at the site where the drugs are placed into vein.

__________3. An irritated vein, called phlebitis, where the needle is placed into a vein. Sometimes this may progress to a level where hand motions may be restricted temporarily, and further medication or care may be required.

__________4. Nausea and vomiting is not common, but are unfortunate side effects of intravenous anesthesia. Bed rest, and sometimes medications may be required for relief.

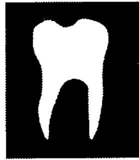
__________5. Intravenous sedation is a serious medical procedure and whether given in a hospital or office, carries with it a risk of brain damage, stroke, heart attack or death.

Your Obligations:

__________1. Because the anesthetic medication causes prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you for several hours until you are recovered sufficiently to care for yourself. Sometimes the effects of the drugs do not wear off for 24 hours.

__________2. During recovery time you should not drive, operate machinery, or make important decisions such as signing legally binding documents, etc.

__________3. You must have a completely empty stomach. It is vital that you have NOTHING TO EAT OR DRINK for 6 hours prior to your anesthetic. TO DO OTHERWISE MAY BE LIFE-THREATENING. Note: if directed by your doctor, sips of water may be used to take regular medications or prescriptions given to you by this office.



CONSENT:

I have read and understand the above statements and directions and realize that intravenous anesthesia carries with it a certain risk. I request that IV sedation analgesia/anesthesia be used for my surgery. All my questions regarding this consent have been answered fully and to my satisfaction, and I fully understand the risks involved.

Signature of Patient or Guardian:______________________________________Date:_________________

I UNDERSTAND THIS PROCEDURE WILL REQUIRE THE USE OF SHARP INSTRUMENTS. THEREFORE, IN THE THE EVENT THAT Dr. Pitts, D.D.S or a member of his staff punctures his/her skin, I give consent to Dr. Matts Pitts DDS to perform all necessary serologic testing for the HV antibody and disclose to appropriate personnel and as may be otherwise required by state or federal law.

RESUSCITATION: Iit is the office policy of Dr. matt pitts that if an adverse event occurs during your treatment/procedure, we will initiate resuscitation or other stabilizing measures and have you transferred to a hospital for further evaluation. At the hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with the hospital policies. Your agreement with the policy by your signature does not revoke or invalidate any current health care directive or health care power of attorney. If you have questions then you should speak with your physician.

Patient or guardian signature:______________________________________Date:_________________

Physician's signature:____Date:_________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What time did you last have anything by mouth? Date:_________________ Time: _______________AM/PM

What did you have?____

I acknowledge that I have been notified not to eat for 6 hours prior to the appointment. YES/NO