



THOMASVILLE
DENTAL CENTER

Informed Consent for Intravenous Sedation

You are scheduled for dental treatment utilizing IV conscious sedation on:

_____ @ _____ AM/PM
DAY DATE TIME

Patients who have a clear understanding and expectation level before sedation and treatment have a greater peace of mind. The following instructions and information will help you prepare yourself and ensure that your experience goes smoothly.

- You may not have anything to eat or drink for six (6) hours prior to your appointment. This includes water, coffee and other "clear" liquids; to do otherwise may be life threatening.
- Any regular medications (high blood pressure, antibiotics, etc.) or medications prescribed by this office should be taken using ONLY A SMALL SIP OF WATER.
- You must have a responsible adult present during surgery and also to drive you home. IV medications cause prolonged drowsiness. You MUST have someone stay with you until you can take care of yourself; this may take up to 24 hours. During your recovery period, you should not drive, operate machinery or complicated devices, or make any important personal or business decisions.
- Please wear loose fitting clothing and low-heeled shoes. You will have monitors attached during treatment.
- Call our office as soon as possible if you develop any cold or flu symptoms such as: Stuffy Nose; Sore Throat; Cough; Sinus Drainage; Fever
- A parent or guardian must sign for and come to the appointment with anyone under 18.

(Initials)

- **RISKS AND COMPLICATIONS:** Include but are not limited to: discomfort, swelling, bruising, infection, allergic reactions, and nausea. There may be inflammation at the site of IV, which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV conscious sedation. **Intravenous conscious sedation is a serious medical procedure and, although considered safe, carries with it the risks and complications of heart irregularities, heart attack, stroke, brain damage, and death.**

I have read the above and I understand that no treatment is without some measure of risk and the risks of the proposed treatment have been explained to me. I certify that I have been given the opportunity to ask questions and that all questions have been answered to my satisfaction. I further request and authorize Dr. Sanders to do whatever he deems advisable and necessary as a result of unforeseen circumstances. I HAVE NOT HAD ANY SOLIDS OR LIQUIDS FOR 6 HOURS BEFORE TREATMENT. I have given a complete and truthful medical history, including all medications, pregnancy, drug use etc.

Signature

Date

Witness