Perio & Implants

Non-Intravenous Conscious Sedation Consent Form

Oral Sedation is provided to minimize anxiety and reduce restlessness during extensive dental procedures which is safe and effective. It is imperative however that the protocol described in this document be closely followed. It is your obligation to inform us if there has been a use of alcohol, marijuana for recreational or medicinal use, any medication for anxiety, anti-depressive or sleeping aid as this may have an effect on the oral sedation. I have given the Doctor a complete medical history and told him of all medications and over the counter medications, herbs, and other supplements I take. I have told the Doctor about all drug, latex and other allergies or sensitivities. I have also disclosed **any alcohol, recreational use of legal or illegal drugs** I have taken within the last 3 weeks, including but not limited to: heroin, crack, cocaine, methadone, opium, methamphetamine, percodan, vicodin, oxycontin, and marijuana.

1. **Please read and ask any questions, understand and sign this form and your surgical consent form prior to taking your pre-operative medication. You are unable to give informed consent while medicated and your procedure will not be performed without your valid, informed consent.**

2. The medication you will be given is Diazepam 10mg (Valium) and Lorazepam 2mg. It is a drug in the benzodiazepam class. This medication has sedative and muscle relaxing properties. You will be given the Diazepam 10mg first and 15mins later you will be given the Lorazepam in our office, approximately 1hr prior to your appointment. **The effects of sedative medications may last more than 48hrs and cause prolonged drowsiness, dizziness, headache, blurry vision, and amnesia. Nausea and vomiting, although not common, are potential side effects of anesthesia.**

3. I give the Doctor and their staff permission to discuss my dental procedures, post-op instructions and any pertinent information for caring for me to my ride/chaperone/care giver, including in person, by telephone, email, etc., as I may not remember what the Doctor and/or his staff told me after I take the medications or be in a good state of mind to care for myself for the rest of the day. If, during the procedure, a change in treatment is required, I authorize the doctor and his staff to make whatever change they deem in their professional judgment is necessary. I also have the right to designate another individual who will make such a decision for me if they are present here in the office at the time. If they cannot be reached, then the doctor and his staff can make the decision.

4. Because this medication is sedative, it effects judgment and response time, and will make you loopy, and sleepy. The effects of sedative medications may cause prolonged drowsiness, dizziness, headache, blurry vision, and amnesia. Therefore use of this medication in conjunction with dental treatment requires you to be escorted to and from your appointment. I will be accompanied by a responsible adult who will stay in the office throughout the procedure, who will drive me to and from my surgery, who will stay with me for the remainder of the day and until I have recovered sufficiently to care for myself. **I will not drive, operate machinery, cook, watch children or make any important or legal decisions for 48 hours after my dental appointment is finished, regardless of how "good" I feel.**

5. **Oral Sedatives** should not be ingested if you are pregnant, or breast-feeding. They should not be taken if

you have kidney or liver disease, if you are hypersensitive to benzodiazepines (Valium, Ativan, Versed, etc) or are taking any medication which adversely interact or amplify the effects of these medications (see medication reconciliation).

6. **It is not necessary to fast prior to dental treatment with Oral Conscious Sedation; in fact a light meal or nutritious shake is encouraged. After your procedure you will remain sedated and should rest, with a companion present, as you may be unsteady and could become disoriented**.

My signature affirms that I understand these instructions and am willing to abide by the conditions described in this document. I have had the opportunity to ask questions, and have had them answered to my satisfaction.

Signature	**Date**	**Time Signed**

Patient, Parent, or Legal Guardian (Must be 18 years of age or older)

Time Diazepam 10mg administered _____ **How many pills**

Time Diazepam 10mg administered _____ **How many pills**

Witness Signature	**Date**	**Time Signed**

Person waiting for patient	**Telephone #**	**Post Op Instructions Received**

Signature of Person who patient is released to	**Time Released**