Oral Sedation Information Sheet and Consent Form

This form is intended to document the discussion we have had regarding your planned conscious sedation procedure for (please indicate procedure being performed)_____.

The medication we will be using is Triazolam (Halcion). This medication can greatly minimize anxiety that may be associated with going to the dentist. In a relaxed state, you will still be able to communicate with the dentist while treatment is being performed. Even though it is safe, effective, and wears off rapidly after the dental visit, you should be aware of some important precautions and considerations.

_____ 1. I understand the benefits of conscious sedation include reduced awareness of unpleasant sights, sounds and sensations associated with the procedure along with reduced anxiety.

_____2. I understand the risks of conscious sedations, though rare, can include: nausea/vomiting, allergy to medication, breathing problems, brain damage, cardiac arrest and death.

_____3. I understand that it is critically important that I fully discuss my complete medical history with the dentist before sedative medications are administered especially any medications I'm taking (including any herbal supplement or vitamins).

_____4. I understand that I should not have sedation done if I am pregnant, breast feeding, or have significant liver or kidney disease.

_____5. I understand that I should have nothing to eat or drink for five (**5**) hours prior to the procedure. I understand that I should still take any normal prescribed daily medications with a small amount of water.

_____6. I understand that I must have an escort (responsible adult 18 years old or older) available and with me for my appointment. My escort MUST be able to drive me to and from the procedure. My escort is responsible for getting my pain medications and ensuring that I eat and drink and take my medications after surgery. This escort must be reliable in order to take care of me properly. If an escort is not present for my appointment I understand it will be cancelled.

_____7. I understand that I have been advised against driving a car or operating any machinery, going up and down stairs alone, using firearms, or signing legal documents for the remainder of the day. I also understand that it is not advisable for me to be responsible for small children after my appointment.

_____8. I understand that I should not consume any caffeine, alcohol, use any tobacco products or patches, or any other stimulants 24 hours before and after my procedure.

_____9. I understand that I should not wear any fingernail polish on the day of the procedure as it may interfere with the oxygen monitoring devices used by the dentist.

_____10. I understand that if I wear contact lenses I should not wear them to my appointment.

_____11. I understand that medication affects each individual differently. In the event that the medication produces less than optimal sedation or no sedation, I will be given the option to continue treatment or be reappointed.

_____12. I understand that 1 hour prior to my appointment time, in the presence of my escort, I should take the Triazolam with a small sip of water and that I may require assistance walking.

_____13. The dentist has reviewed these written instructions with me including expectations regarding food/drink intake, escort and activity after the sedation.

Informed Consent: I have been given the opportunity to ask any questions regarding the nature and purpose of this treatment and have received answers to my satisfaction. I have been given other options or alternative treatments. I understand that conscious sedation is elective and not required in order to take care of my dental needs. I consent to the risks of the procedure as they have been explained to me. I understand the desired results may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. By signing this form, I am freely giving my consent to allow and authorize Dr. Wietholder and his staff members to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

_____ _____ _____

Patient's name (please print) Patient Signature Date