Informed Consent for Intravenous Sedation

I have elected to proceed with intravenous sedation in conjunction with my dental treatment.

Purpose of Intravenous Sedation: I understand that the purpose of intravenous sedation is to more comfortably receive necessary dental care. I understand that intravenous sedation is a drug-induced state of reduced awareness and decreased ability to respond but that it does not produce a state of sleep.

Risk and Complications of Intravenous Sedation: I have been informed of, and understand, the while Intravenous sedation is considered safe, potential risks associated with anaesthesia include, but are not limited to:

- Allergic or adverse reactions to medications or materials;
- Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed (phlebitis) which may cause prolonged discomfort and/or disability, and may require special care. Usually the numbness or pain goes away, but in some cases may be permanent;
- Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness.
- Some patients may have awareness of some or all of the events of the cleaning or surgical procedure after it is over;
- A remote possibility of complications that would require transportation to a hospital for treatment and could lead to brain damage, stroke, heart attack, coma or death.

Patient's responsibilities
I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, allergies, recreational drug, tobacco and alcohol use, and pregnancy/lactation (if applicable).

I understand that I must have an empty stomach and have followed the fasting guidelines as outlined for my case and that doing otherwise may be life-threatening. If instructed, I have taken my regular medications and or medicine given to me by my doctor using only small sips of water. I am accompanied by a responsible adult to drive me to and from the office and he/she will stay with me after the procedure until I am recovered sufficiently to care for myself.

I understand the drugs given to me for this procedure may not wear off for 24 hours. During my recovery from anaesthesia, I agree not to drive, operate complicated machinery or devices, or make important decisions such as signing documents.

I had sufficient time to read this document, understand the statements, and have had a chance to get all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of my anaesthetic and agree to proceed.

_____	_____	_____
Patient's Signature	Date	Patient's Name
_____	_____	_____
Signature of Patient Guardian	Date	Relationship to Patient
_____	_____	
Signature of Witness	Date	

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed anaesthesia. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and believe that the patient and/or the patient's legal representative fully understands what I have explained.

_____	_____
Signature of Anaesthesia Provider	Date

_____
Title