FAIRFIELD
Dental Arts

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## Instructions and Consent Form for Patients Receiving Intravenous Conscious Sedation

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

1. You may not have anything to eat or drink (including water) at least eight (8) hours prior to the appointment. You should, however, take any medications that your surgeon has directed you to take before your surgery with a ***small sip*** of water. If you are diabetic, please do not take your diabetes medication(s) the night before or the day of surgery.

2. Any personal illness, weakness, or known susceptibility must be reported to Dr. Nill. Also, details of drugs recently prescribed or being taken especially sleeping drugs, tranquilizers or cortisone preparations.

3. Make arrangements to have someone bring you to your appointment ***and*** wait in the office to drive you home after your appointment. **YOU MUST HAVE AN ADULT STAY WITH YOU AFTER SURGERY. YOU MUST NOT BE LEFT UNATTENDED.**

4. Any patient accepting any appointment for these techniques must specifically agree:
   a. Not to drive a vehicle or operate any machinery the same day.
   b. Not to undertake any responsible business matters
   c. Avoid alcohol

5. Please wear loose fitting clothing with short sleeves or sleeves which can be rolled up past the elbow. Contact lenses (non-extended), jewelry, dentures and nail polish must be removed.

6. A parent or guardian must sign for and come with anyone who is a minor under 18 years of age.

7. All intravenous solutions are irritating to a degree and although all precautions will be taken to minimize these effects, vein irritation following these procedures can occur.

Special Instructions: _____.

_____.

I have read the above instructions and consent to having my dental treatment done with intravenous conscious sedation. During sedation, I understand the inability to discuss treatment options with the dentist should the circumstance require a change in the treatment plan. If a change in treatment is required, I authorize the dentist and sedation team to make whatever change they deem in their professional judgment is necessary.

I understand there are limitations and/or risks to all procedures and that there could be an unusual reaction to sedation, which may require emergency medical treatment and/or hospitalization. These risks include but are not limited to cardiac arrest, brain injury, and death. I have had the opportunity to discuss conscious sedation and have my questions answered by the dentist.

Printed Name: _____ Signature: _____ Date: _____.

Appointment Date: _____ Time: _____.