

INFORMED CONSENT FOR IV CONSCIOUS SEDATION AND ORAL SEDATION



MIKE WILLIAMSON
DDS | MS

The following is provided to inform our patients of the choices and risks involved with having treatment under anesthesia. This information is not presented to make patients more apprehensive but to enable them to be better informed concerning their treatment. There are three basic choices for pain and anxiety: local anesthesia alone, conscious sedation, or general anesthesia. These can be administered, depending upon each individual patient's medical requirements, either in an office or in a hospital setting.

I, hereby authorize and request Dr. Michael Williamson to perform the anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize and request the administration of such anesthetic or anesthetics (from local to conscious IV sedation) by any route that is deemed suitable by the administrator.

Local anesthetic will be administered, and sedative drugs (oral and/or IV) may be used to reduce my anxiety and discomfort by making me relaxed and sleepy. Sedative drugs may reduce my ability to remember events occurring on the day of the operation. I recognize that I must do several things in connection with sedation. I must refrain from eating six (6) hours before my appointment. I must not drink any alcohol or use recreational drugs 12 hours before and 24 hours after the procedure. I understand and agree that if sedative drugs are utilized before and/or during surgery I will not drive myself to or from the office and will arrange to have a responsible adult drive me home and accompany me until I am fully recovered from the effects of the sedation. I agree to not operate a motor vehicle or hazardous machinery for 24 hours after surgery. I have been advised not to make any major decisions until after recovery from anesthesia.

I have been informed and understand that occasionally there are complications of the drugs and anesthesia, including but not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, and fluctuations in breathing patterns, heart rhythm and/or blood pressure. I further understand that, in extremely rare instances, damage to the brain or other organs supplied by an artery and even death, can occur.

I understand that anesthetics, medication, and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. Williamson of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For the same reason, I understand that I must inform Dr. Williamson if I am a nursing mother.

I have read this entire form and understand everything explained in it. I have had the opportunity to ask Dr. Williamson about any questions I may have about the treatment, the risks of surgery or sedation, and the alternative treatment methods. I hereby consent to the performance of oral and IV sedation as presented to me. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgement of Dr. Williamson. I authorize that my treatment and/or financial information may be discussed with family members, guardians, or accompanying chaperones.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT:

.....
SIGNATURE of patient, parent, or guardian

.....
Date

.....
SIGNATURE of witness

.....
Date