Summit View Periodontics

Minimum Oral Sedation/Anxiolysis Informed Consent

The purpose of this document is to provide an opportunity for patients to understand and give permission for Minimal Oral Sedation (MOS)/anxiolysis (oral premedication for mild to moderate forms of dental anxiety) when provided along with dental treatment. Please read each item carefully.

1. I understand that the purpose of MOS/anxiolysis is to receive necessary care more comfortably. Anxiolysis is not required to provide the necessary dental care. I understand that the MOS/anxiolytic medication has limitations and risks. Absolute sedation success cannot be guaranteed.

2. I understand that MOS/anxiolysis (defined as the diminution of anxiety) is a mild drug-induced state of reduced awareness and decreased ability to respond. MOS/Anxiolysis is not sleep. I will be able to respond during the procedure. My ability to respond normally returns when the effects of the sedation wear off.

3. I understand that **<u>all consent forms MUST be signed prior</u>** to the administration of the oral anxiolytic drugs. If not, it may be necessary to abort my scheduled procedure.

4. I understand that my sedation will be achieved by oral administration. Some medication may be prescribed for a good night sleep the night before the procedure. The day of the procedure, I will take one (1) pill approximately one (1) hour before my appointment, or as directed. I will bring any remaining pills to my appointment. Additional pills and/or nitrous oxide inhalation may be administered in the dental office based upon the desired effect.

5. I understand that there are alternatives to MOS/anxiolysis medications. They are:

    a. No sedation. The necessary procedure being performed under local anesthetic only.

    b. Inhalation anxiolysis: Nitrous oxide sedation (“Laughing Gas”)

    c. Oral anxiolysis: Taking pills to reduce fear and anxiety.

    d. Intravenous conscious sedation: Drugs administered directly by access to your vein.

    e. General Anesthesia

6. I understand that there are risks and limitations to all procedures. For anxiolysis these include:

    a. With initial dosage may require the patient to undergo the procedure without full effect or delay the procedure for another time.

    b. Atypical reaction to the sedative medications. In unusual circumstances this may require emergency medical attention and/or hospitalization. Other atypical reactions may include: altered mental states (e.g. oversedation or hyper responding to the sedative medication), allergic reactions, and nausea and/or vomiting.

c. Inability to discuss treatment options with the doctor should circumstance require a change in treatment plan.

7. If a change in treatment is required during the procedure, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary to protect my general and oral health. I understand that I have the right to designate an individual who will make such a decision.
8. I will notify the doctor if I have sensitivity to any medication, of my present mental and physical condition, if I have recently consumed alcohol, smoked/consumed marijuana, or if I am presently on psychiatric mood altering drugs and medications.
9. I will not consume any citrus fruits/juices within 24 hours of taking any sedative medications.
10. **(Women)** I understand that I must notify the doctor if I am pregnant, planning a pregnancy, or if I am lactating. If I could possibly be pregnant, I will conduct a pregnancy test prior to taking any sedative medications.
11. **(Men)** I have not consumed any erectile dysfunction (E.D.) medications within 48 hours of taking any sedative medications.
12. I will not be able to drive/operate machinery, sign documents, or engage in multimedia activity (text/e-mail/post) while taking oral sedatives and for at least 24 hours after my procedure. I understand that I will need to make arrangements for someone to drive me to and from my dental appointment while taking oral sedatives.

Patient Consent: I hereby certify that I understand this authorization and the reasons for the above named sedative procedure and associated risks. I am aware that the practice of dentistry is not an exact science. I acknowledge that every effort will be made on my behalf for a positive outcome from sedation, but no guarantees have been made to the result of the procedure authorized above. All questions regarding my therapy have been answered to my satisfaction.

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(Date) (Signature of patient/parent/guardian) (Printed name of patient/parent/guardian)

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(Date) (Doctor's signature)

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(Date) (Signature of witness) (Printed name of witness)