

## CONSENT FOR ORAL CONSCIOUS SEDATION

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Patient's Name \_\_\_\_\_

Date \_\_\_\_\_

**Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.**

You have chosen **oral conscious sedation** for your treatment. You have the right to be informed about this so that you can decide whether to have it or not after knowing the risks and benefits. These common procedures are considered quite safe. Nevertheless, all procedures have some risks. They include the following and others:

- \_\_\_\_ 1. Allergic reactions (previously unknown) to any of the medications used.
- \_\_\_\_ 2. Nausea and vomiting, although not common, are possible unfortunate side effects. Bed rest, and sometimes medications, may be required for relief.
- \_\_\_\_ 3. Oral conscious sedation is a serious medical procedures and, whether given in a hospital or office, carry the risk of brain damage, stroke, heart attack or death.

### **YOUR OBLIGATIONS:**

- \_\_\_\_ 4. Because anesthetic or sedative medications (including oral premedication) causes drowsiness that lasts for some time, I **MUST** be accompanied by a responsible adult to drive me to and from surgery, and stay with me for several hours until you are recovered sufficiently to care for myself. Sometimes the effects of the drugs do not wear off for 24 hours.
- \_\_\_\_ 5. During recovery time (normally 24 hours), I should not drive, operate complicated machinery or devices or make important decisions such as signing documents, etc.
- \_\_\_\_ 6. I must have a completely empty stomach. It is vital that I have **NOTHING TO EAT OR DRINK** for **six (6) hours** prior to your treatment. **TO DO OTHERWISE MAY BE LIFE-THREATENING.**
- \_\_\_\_ 7. **Unless instructed otherwise**, it is important that I discuss which regular medications (high blood pressure, antibiotics, etc.) I should take prior to my oral conscious sedation. **If instructed to take medications, take using only a small sip of water.**

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**CONSENT**

I have read and understand the above paragraphs and realize that conscious sedation has certain serious risks. I request that my choice be used for my treatment. I fully understand the risks involved. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All my questions have been answered before signing this form.

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Patient's (or Legal Guardian's) Signature

Date

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Doctor's Signature

Date

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Witness' Signature

Date