Lakeshore **W**est **D**ental
3390 Lake Shore Blvd., W. Office: 416-251-5707
Etobicoke, Ontario, M8W 1M9 lakeshorewestdental@gmail.com

CONSENT FOR SEDATION

Patient Name: _____

It is our moral and legal obligation to give you the information necessary to make an educated decision in requesting treatment. The benefits of the therapy are usually greater than the risk, but just as there are risks involved in driving a car, there are events that can occur with any type of treatment. These are being explained to inform and educate you and not to alarm you. Eliminating surprise will make your care go more smoothly. As with any dental procedure you must advise us of your medical status including a complete disclosure of all medications and/or drugs you are currently taking with special notice to us if you are pregnant or have glaucoma. _____**Initial**

Post op reactions:

1. Minor oozing of blood from the surgery site. Apply pressure to decrease any oozing.
2. Postoperative discomfort and swelling which may require several days of home recuperation.
3. Chapping of the lips caused by stretching the corners of your mouth during surgery.
4. Stiffness of the jaw and restricted mouth opening for several days or weeks depending on the extent of the treatment.
5. Possible temporary amnesia.

Rare occurrences can include any event that might be remotely possible but unlikely to occur. People rarely plan their lives around these, but they can occur. These include: allergic reactions to drugs, which range from hives to heart failure. Many drugs reactions are side effects and treated as such. The office staff has had training in managing these potential problems. _____ **Initial**

Medication, drugs, anesthetics and prescription may cause drowsiness and lack of awareness and co-ordination, which can be increased by the use of alcohol or other drugs. It would not be wise to operate any vehicles, automobiles or hazardous devices while taking such medication and or drugs. Your judgment and work performance can be altered by pain medication or the sedative agents and you should plan accordingly. Your signature below certifies:

1. Your consent and request for Dr. Sam Patel or any dentist working with him to perform the following treatment, procedure or surgery…Full treatment as described in my treatment plan.
2. Your understanding that on rare occasions, individual patients differences can result in relapse of a condition in spite of our efforts to provide optimum care. In this event you understand that selective re-treatment may be necessary.
3. Your agreement to the administration of anesthesia, nitrous oxide/oxygen and/or sedation as discussed with Dr. Sam Patel or any other dentist working with him.
4. Your authorization for Dr. Sam Patel to use his best judgment in managing unforeseen conditions, which unexpectedly arise during the course of the procedure.
5. Your understanding that lack of co-operation with our recommendations during your care may result in less than optimum results.
6. I have been informed that Dr. Sam Patel is a general dentist and a referral to a specialist has been offered.
7. That you read and write English, understand the above information and have the opportunity to review and discuss it as well as your health history including any serious problems or injuries.
8. That all statements requiring insertion or completion were filled in, and inapplicable paragraphs, if any were stricken before you sign.
9. You are both mentally and physically competent to give this consent.

Witness _____ Date_____

Patient/Parent Guardian _____ Date_____

Doctor _____ Date_____