Mayfair Dental IV Sedation Package

- ☐ Patient name: _____
- ☐ Provider / Apt length: _____
- ☐ IV sedation forms given: _____
- ☐ Preauthorization sent: _____
- ☐ Faxed MSP (if apt is 4 hours): _____
- ☐ Patient estimate sent: _____
- ☐ Health/Physicians consent returned: _____
- ☐ IV sed non- refundable deposit made: _____
- ☐ Date and time of IV sed apt: _____
- ☐ Faxed consent to anaesthetist: _____

IV Sedation Consent Form

I hereby consent to the administration of deep intravenous sedation while having my dental treatment.

I have discussed this with the dentist who is doing my dental work/surgery. I understand I will be given the opportunity to discuss the sedation with the anaesthesiologist on the day of my appointment.

_____

print full name

_____ _____ _____

Patient Signature (or guardian, if required) | Witness Signature | Date

Patient Address: _____

Home Phone: _____ Work Phone: _____

Personal Health Number: _____ Date of Birth (D/M/Y) _____

Dentist: _____ Physician: _____

Date of Appointment: _____ Time of Appointment: _____

Even though you have answered health questions elsewhere, please fill in the following medical questionnaire to help the anaesthesiologist make decisions about your sedation.

List all your medications: _____

_____

_____

List all your allergies: _____

_____

_____

List any problems you have had with previous sedation or with general anaesthetic:

_____

_____

_____

Do you have now, or have you had in the past:

Heart Problems: (circle all that apply) YES NO

heart valve problems I heart attack I surgery I chest pain/angina I heart murmur I congestive heart failure I other:

_____

Lung Problems: (circle all that apply) YES NO

asthma I chronic bronchitis I emphysema I shortness of breath I other:

_____

High Blood Pressure: YES NO

Diabetes: YES NO

Kidney Problems: YES NO

Stomach/Intestinal Problems (including acid reflux/GERD) : YES NO

Psychiatric Treatment: YES NO

continued on reverse

IV Sedation Consent Form continued

Cancer:	YES	NO
Radiation/Chemotherapy:	YES	NO
Steroid therapy within the last 6 months:	YES	NO
Heart valve replacement/Joint replacement:	YES	NO
Liver problems:	YES	NO
Bleeding or Blood clotting problems:	YES	NO
Convulsions, Fainting Spells, Seizures:	YES	NO
Alcohol or Drug dependence:	YES	NO
Hepatitis or hepatitis contacts:	YES	NO
HIV (AIDS) or contact with HIV (AIDS):	YES	NO

If not mentioned above or on previous page, *list any serious illnesses you have had in the past (even if they don't need treatment now):*

If not mentioned above or on previous page, *list any serious illnesses you currently have (even if they don't require treatment):*

Do you smoke: (if yes how many cigarettes/pipes per day?)	YES	NO
Do you wear contact lenses:	YES	NO
Do you have a pacemaker:	YES	NO
Do you snore or have sleep apnoea:	YES	NO
Do you have a family history of: (circle all that apply) bleeding problems I anaesthesia problems I other medical problems:	YES	NO

What is your height:

What is your weight:

WOMEN ONLY:

Are you pregnant:	YES	NO
Are you on the birth control pill:	YES	NO

Name of person driving you to the clinic and home on day of surgery: _____

Contact phone number for driver: _____

I the undersigned agree that the above information is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted to obtain further medical information.

_____ _____

Signature **Date**

☐ **patient** ☐ **parent** ☐ **guardian**

Physician Consent for patients Requiring IV Sedation

Mayfair Dental Centre
#186-3147 Douglas St. Victoria, B.C. V8Z 6E3
Telephone:250-384-1154 Fax number:250-384-8936

Attn:Physician

From:_____

Patient:_____

Date of Birth:_____

Personal Health Number:_____

Date:_____

RE: DENTAL TREATMENT UNDER INTRAVENOUS SEDATION

This patient requires dental treatment, and under my recent dental consultation it was determined that this treatment cannot be carried out without intravenous sedation.

As of April 2001 the Medical Services Plan requires confirmation from the patients family doctor confirming that he/she has a either a significant dental phobia,severe gag reflex, and/or a medical condition preventing patient from tolerating dental treatment without intravenous sedation.

I believe that this patient,_____has_____.

I would like to commence this treatment in the near future. To simplify your confirmation of this patients reason for requiring IV sedation,I would ask that you sign this letter where indicated,and return to my office as soon as possible.

Many thanks,

I concur with Dr. _____ that this patient has a significant clinical dental phobia and/or severe gag reflex. This patient will require intravenous sedation anesthesia to allow dental treatment to be carried out.

Signed

Dr._____

Before Your Sedation

NOTE: Please read these instructions carefully today and again on the day before your sedation appointment.

Pre-operative Sedation:

- If you take any sedation before your appointment – do not drive from that moment on

Food And Beverages:

It is essential that your stomach is EMPTY at the time of appointment, therefore:

- do not eat any solid food or drink milk for 6 hours before the appointment
- do not drink any liquids, even water, for 3 hours before the appointment
- In the period between 6 and 3 hours before the appointment you may drink 2 to 3 cups or small glasses (about the size of a cup) of clear fluid, i.e. water, juice without pulp, tea or coffee without milk or milk substitutes
- any meals you are allowed on the day of surgery should be light
- do not drink alcohol for 24 hours prior to the appointment

Prescription Medication:

- **do not** change the dose of your medications and **do not** discontinue them prior to you surgery without the consent of both your family doctor and the anaesthesiologist
- despite the restrictions on food and beverages above you may (and should) take your medications with a sip of water whenever they become due - unless specifically instructed by the anaesthesiologist not to take a particular medication
- bring all your prescription medications with you on the day of surgery. Bring them in their original containers with the pharmacist's label still on

Diabetics on insulin should contact the anaesthesiologist (via the dental office) as different instructions may apply to them.

Clothing / Contact Lenses:

- wear loose casual clothing. Female patients should wear slacks
- remove contact lenses at home, before leaving for your appointment
- do not wear jewelry, hairpins or make-up

Tongue studs/rings, nose and lip jewelry must be removed.

Going Home:

- you must have someone to drive you home when the surgery is completed
- that person must come up to the office to escort you to the car
- someone needs to stay with you for 6 hours after the surgery

Change In Health Status:

If your general health deteriorates (i.e. cold, cough, fever or worsening of some chronic health problem, etc.) before the day of the appointment contact the dental office. If in doubt, please phone the office to discuss any changes in health status.

If you have any questions, please do not hesitate to ask them.
It is important that you understand all the implications of your treatment.

After Your Sedation

NOTE: Please read these instructions carefully before you go in for your appointment, and be sure to take them home with you so you can refer to them when you need to.

Discharge From The Office:

- you must have someone to drive you home
- that person must come up to the office to escort you down to the car
- you need to have someone with you for at least 6 hours after the surgery

Food And Beverages:

Nausea is unusual after IV sedation, however:

- do not eat or drink anything that is too hot before the local anaesthetic (freezing) wears off
- do not have large amounts of food or liquids in the first 2 hours
- do not drink alcohol for 48 hours

Prescription Medications:

- resume your medications when they become due, unless you have specific instructions not to do so by the anaesthesiologist

Activity Restrictions:

- do not operate motor vehicles, bicycles, boats, power tools or machinery for at least 24 hours, or longer if drowsiness or dizziness persists
- those wishing to operate an aircraft following deep sedation should seek guidance from applicable aviation authorities and/or their employers
- do not cook for 24 hours (you do not want to spill hot food or liquids on yourself)
- do not perform any work that requires important decisions be made for at least 24 hours, or longer if drowsiness or dizziness persists

Problems:

Post-operatively, if you experience any acute pain, heavy bleeding from the surgical site, respiratory problems or any other problem, please notify the dental office.