CONSENT FOR ANXIOLYTIC MEDICATIONS

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

PATIENT NAME:_____DATE_____

You have chosen prescription medication to decrease nervousness for your next appointment with Dr. Steinhubel. You will be given medications that will make you feel relaxed and sleepy; however, you will NOT be asleep. You will have one pill the night before your appointment to help you get a good night's sleep. You will take a pill 45-60 minutes prior to the procedure, and will have one to bring with you, should you and the doctor feel another is needed once you arrive at our office. At the appointment time, local anesthetics will be used to prevent any pain during the procedure. The prescription medication is quite common for dental procedures and is considered relatively safe. Nevertheless, any medication carries some risks and side effects, the common ones known are noted below for your review before you consent to its use.

1. Allergic reactions to any of the medications used. Be sure you have informed us of all allergies you have.

_____2. Nausea and vomiting, although not common, are possible side effects of this medication. Bed rest, and sometimes-additional medications, may be required for relief.

3. Anxiolytic medication, although quite safe at this dose, is a sedative, which decreases breathing and that carries with it the risk of brain damage, heart attack, or death.

_____4. Nitrous oxide/oxygen in addition may be added if needed to relax you.

YOUR OBLIGATIONS:

_____1. Because the medication causes prolonged drowsiness, (Sometimes the effects of the drugs do not wear off for 24 hours) you MUST be accompanied by an escort. YOUR ESCORT MUST BE A RESPONSIBLE ADULT WHO WILL ARRIVE WITH YOU, REMAIN IN THE DENTAL OFFICE DURING YOUR PROCEDURE, AND DRIVE YOU HOME. FOR THE REST OF THE DAY YOUR ESCORT MUST BE PHYSICALLY PRESENT AND WILL BE RESPONSIBLE FOR YOUR SUPERVISION AS NEEDED.

_____2. Please notify your doctor prior to your appointment of any change in your health. Examples include cold symptoms or any other illness, new medications, possibility of pregnancy, ETC.

_____3. No food or water (except water with meds) for six hours prior to appointment.

4. No sedatives, including alcohol or narcotics, for 24 hours before/after your appointment (other than the medication prescribed by Dr. Steinhubel). If you are diabetic, inform us.

_____5. No stimulants for 12 hours before/after your appointment.

_____6. No sensitivities to Benzodiazepines, Hydroxyzine, Zaleplon.

_____7. DO NOT wear contact lenses or heavy makeup. Need a bare fingernail for a sensor (remove one acrylic nail if necessary).

_____8. Wear short sleeves so a blood pressure cuff and monitor can be applied. A blanket will be provided if you feel chilled.

_____9. Full mental alertness may not return for several hours. For the following 24 hours, **DO NOT:**

_____ a. Drive a vehicle or operate machinery.
_____ b. Undertake business matters or make life decisions
_____ c. Drink alcoholic beverages
_____ d. Any task that requires mental and/or physical full capabiltiy

_____10. These instructions are for your safety. If you have any questions, please ask your doctor prior to your appointment time.

CONSENT: I have read and understand the above paragraphs and realize that conscious oral sedation carries with it certain risks and responsibilities. I request that conscious oral sedation be used for my surgery/dental procedure. All my questions have been answered fully to my satisfaction regarding this consent and I fully understand the risks involved. I also state that I speak, read and write English.

_____

Patient's (or legal guardian's) signature Date and Time

_____

Witness' signature Date

_____

Doctor's signature Date

I will be physically present and responsible for this patient for the remainder of the day and longer if needed.

_____

Escort's signature Date