



Moderate Sedation Consent Form

AUTHORIZATION for the ADMINISTRATION of CONSCIOUS (MODERATE) SEDATION

It has been explained to me that a dentist or that a credentialed dental assistant or dental hygienist nurse under the direct supervision by a dentist will administer Conscious Sedation (also known as moderate sedation, procedural sedation, or sedation and analgesia) for the following procedure:

I hereby authorize such administration of conscious sedation. I understand that conscious sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone, or accompanied by light tactile stimulation. No interventions are usually required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

I also understand that during the course of the proposed conscious sedation unforeseen conditions may arise. I authorize the dentist to perform any additional procedures deemed necessary. I authorize the utilization of emergency resuscitative measures, emergency Endotracheal Intubation or other necessary measures to maintain the airway, and transfer to another facility as needed for any advanced level of care.

I understand that conscious sedation involves potential risks, which may include drowsiness, nausea, vomiting, and amnesia, awareness during the procedure, headaches, muscle aches, sore throat, hoarseness, and feelings of weakness or breathlessness. There is a significant risk I may slip into a deeper state of sedation than anticipated or planned including the state of full general anesthesia. Rare potential risks include injury to teeth, vocal cords, peripheral nerves, skin, respiratory and cardiovascular problems, and loss of function of any and all organ systems, loss of sensation, muscle weakness, infection, allergic reaction, drug reaction, nerve injury, sexual or other hallucinations, heart attack, cardiac arrest, brain damage, stroke or death.

I am aware that other unexpected complications may occur and I acknowledge that no guarantees or warranties have been made to me concerning the results of the administration of conscious sedation. The potential benefits and risks of the proposed procedure and the administration of conscious sedation have been explained to me, the likely results without conscious sedation and the available alternatives have been explained to me. I hereby certify that I have fully understood the above treatment plan and authorization, and that all my questions have been answered.

Signature of Patient or Surrogate

Date & Time

Witness

I have explained the risks, benefits, and alternative to the patient or authorized representative whose signature is affixed above.

Independent Licensed Practitioner

Date & Time