

## INFORMED CONSENT FOR ANESTHESIA

*The following is provided to inform patients, and/or parents of minor children of the choices and risks involved with having dental treatment under anesthesia. This information is not presented to make patients, parents, or legal guardians more apprehensive, but to enable them to be better informed concerning their treatment. There are basically four choices for anesthesia: local anesthesia, conscious sedation, general anesthesia, and/or no anesthesia. These can be safely administered in an office, surgery center, or hospital setting.*

I understand that the most frequent side effects of any anesthesia are drowsiness, nausea/vomiting, and phlebitis. Most patients remain drowsy or sleepy following their surgery for the remainder of the day. As a result, coordination and judgment will be impaired for as long as 24 hours. It is recommended that adults refrain from activities such as driving, and children remain in the presence of a responsible adult during this period. Nausea and vomiting following anesthesia will occur in approximately 10-15% of patients. Phlebitis is a raised, tender, hardened, inflammatory response at the intravenous site. The inflammation usually resolves with local application of warm moist heat; however tenderness and a hard lump may be present up to a year.

I have been informed and understand that on rare occasions, anesthesia related complications include, but are not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, and pneumonia. I further acknowledge, understand, and accept the extremely remote possibility that complications may require hospitalization, and/or result in brain damage, heart attack, or death. I have been made aware that the risks associated with local anesthesia, conscious sedation, and general anesthesia vary. Of the three choices of anesthesia, local anesthesia is usually considered to have the least risk, and general anesthesia the greatest risk.

I understand that anesthetics, medications, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. \_\_\_\_\_ of the possibility of being pregnant or a confirmed pregnancy, with the understanding that this will necessitate the postponement of the anesthesia. For the same reason, I understand that I must inform the anesthesiologist if I am a nursing mother.

Since medications, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination, I have been advised not to use alcohol or other drugs for 24 hours. Also, I have been advised not to make any major life decisions or operate any vehicle and/or hazardous device for at least 24 hours until fully recovered from the effects of the anesthetic, medications, and drugs that have been given to me or my child. I have been advised of the necessity of direct "one-on-one" parental supervision of my child for twenty-four hours following their anesthesia.

I hereby authorize and request the attending dentist anesthesiologist, Dr. \_\_\_\_\_, to perform the anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize and request the administration of such anesthetic or anesthetics (local to general) by any route that is deemed suitable by the anesthesiologist, who is an independent contractor and consultant. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia and this is an independent function from the surgery/dentistry performed while under anesthesia and that the dentist assumes no liability for the anesthesia.

I have been fully advised and completely understand the alternatives to conscious sedation and general anesthesia. I accept the possible risks, side effects, complications and consequences of anesthesia. I acknowledge the receipt of and understand both the preoperative and post-operative anesthesia instructions. It has been explained to me and I understand that there is no warranty and no guarantee as to any result and/or cure. I have had the opportunity to ask questions about my or my child's anesthesia, and I am satisfied with the information provided to me. It is also understood that the anesthesia services are completely independent from the operating dentist's procedure.

**I have read and understand the consent for anesthesia. I have had the opportunity to have all my questions answered regarding the risks, benefits, and alternatives of anesthesia.**

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian's Name** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Witness** \_\_\_\_\_

(Consent to be signed by patient, parent, or legal guardian)