Pediatric Dentistry
Orthodontics
TRUPKIN • WILENTZ • CHIZNER

GENERAL ANESTHESIA/IV SEDATION CONSENT

I, the undersigned parent or legal guardian of the child receiving treatment, hereby give my consent for my child to receive a general anesthetic prior to the dental procedure(s) in order to achieve IV SEDATION / General anesthesia. I have agreed to the use of the anesthetic(s) to achieve the desired anesthesia affect. However, I understand that the desired state of anesthesia may not be achieved alone and other anesthetic procedures or drugs may be required. I consent to the use of these additional procedures and drugs.

I understand the risks inherent in anesthesia. I have discussed these risks with the anesthesiologist who will be providing this treatment and acknowledge that they include, but are not limited to: allergic reaction, infection, bleeding, phlebitis (irritation of vein), nausea, blood clots, loss of limb function, paralysis, stroke, heart attack, brain damage, or death.

I am aware of the fact that I will be responsible for monitoring my child for at least 24-48 hours after the procedure. I understand that I must have a responsible adult transport the patient to and from the office and care for the patient with complete supervision.

I agree to have my child abstain from any food or drink (except clear liquids) for at least 8 hours before the procedure(s) or course(s) of treatment. I understand that my not refraining may result in complications during or postponement of the procedure(s) or course(s) of treatment.

I give permission for the anesthesiologist and any of his/her qualified associates to administer the anesthetic.

I have been given the opportunity to ask questions and express concerns I have about the anesthesia, including the reasoning my dentist has recommended IV sedation/General anesthesia. I acknowledge that the providers involved has answered my questions and addressed my concerns, and provided the risks and benefits of both IV sedation/general anesthesia AND other treatment options, including the option to not perform dental treatment. I understand that treatment for my child may change while in the operatory pending the child's dental status and the pediatric dentist's findings while evaluating my child's teeth. To limit the amount of time my child is under general anesthesia/sedation, I understand the dentist will try their best to notify me of any changes to the dental treatment plan, but may not be able to until the end of the procedure. I understand the anesthesiologist will likely use a restraint to protect and keep my child safe while in the chair under general anesthesia/sedation.

I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

I understand there will be a non-refundable deposit of $250 required prior to booking IV sedation. This deposit will not be refunded if my child's treatment needs to be re-scheduled or cancelled.

_____ _____

Parent/Guardian's Signature Name of patient receiving IV sedation/General anesthesia

_____ _____

Today's Date Witness's Signature