FUNDY DENTAL CENTRE
7322 Highway 1
Coldbrook, NS B4R 1B9

Dr. Scott Schofield, BScH, DDS
Dr. Elizabeth Jackson, BScH, DDS
Dr. April Nason, BSc, DDS

CONSENT FOR ORAL SEDATION

It is our moral and legal obligation to give you the information necessary to make an educated decision in requesting treatment. The benefits of the therapy are usually greater than the risk, but just as there are risks involved in driving a car, there are events that can occur with any type of treatment. These are being explained to inform and educate you, not to alarm you. Eliminating surprise will make your care go more smoothly. As with any dental procedure you must advise us of your medical status including a complete disclosure of all medications and drugs (prescribed or otherwise) you are currently taking with special notice to us if you are pregnant or have glaucoma.

Post op reactions:

1. Minor oozing of blood from surgery sites. Apply pressure to decrease any oozing.
2. Postoperative discomfort and swelling which may require several days of home recuperation.
3. Chapping of the lips caused by stretching the corners of your mouth during treatment.
4. Stiffness of the jaw and restricted mouth opening for several days or weeks depending on the extent of the treatment.
5. Possible temporary amnesia or numbness.

Side effects with sedation are possible but are rare and unlikely to occur. These include: allergic reactions to drugs, which range from hives to heart failure. Many drug reactions are side effects and thus are treated as such. The office staff have been trained in managing these potential problems.

Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and co-ordination, which can be increased by the use of alcohol or other drugs. We recommend you do not operate any vehicles, automobiles or hazardous device while taking such medication and or drugs. Your judgment and work performance can be altered by pain medication or the sedative agents and you should plan accordingly. Your signature below certifies:

1. Your consent and request for Dr. Schofield or any dentist working with him to perform the treatments, procedures or surgery described in my treatment plan.
2. Your understanding that on rare occasions, individual patient differences can result in relapse of a condition in spite of our efforts to provide optimum care. In this event you understand that selective re treatment may be necessary.
3. Your agreement to the administration of anesthesia and oral sedation as discussed with Dr. Schofield.
4. Your authorization for Dr. Schofield to use his best judgment in managing unforeseen conditions, which may unexpectedly arise during the course of the procedure.
5. Your understanding that your lack of co-operation with our recommendations during your care may result in less than optimum results.
6. You have been informed that Dr. Schofield is a general dentist and a referral to a specialist has been offered, if applicable.
7. You fully and completely understand the above information and have had the opportunity to review and discuss it as well as your health history including any serious problems or injuries.
8. That all statements requiring insertion or completion were filled in, and inapplicable paragraphs (if any) were stricken before you sign.
9. You are both mentally and physically competent to give this consent.

Witness_____ Date_____

Patient/Parent Guardian_____ Date_____

Doctor _____ Date_____