Oakville
SLEEP DENTISTRY
FOR KIDS & ADULTS

DR. RAVI VASUDEVA
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Informed Consent for Anesthesia

I understand that the purpose of an informed consent is to make me aware of the choices and risks involved with having procedures performed under anesthesia so that I can make well informed decisions concerning my treatment. The choices of anesthesia are determined on an individual basis. The choices of anesthesia are: local anesthesia alone, IV conscious sedation and IV general anesthesia.

I hereby authorize and request Dr. Vasudeva to perform the anesthesia 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 (from local to general) by any route that is deemed suitable by Dr. Vasudeva. It is the understanding of the undersigned that Dr. Vasudeva will have full charge of the administration and maintenance of anesthesia, and that this is an independent function from the surgery/ dentistry.

I have been informed and understand that occasionally there are anesthesia related complications, including but not limited to: pain, hematoma, numbness, swelling, bleeding, nausea, vomiting, delay in recovery, allergic reactions, laryngospasm, fluctuations in breathing pattern, heart rhythm and or blood pressure. I further understand and accept the extremely remote possibility that life-threatening complications may occur, requiring hospitalization. The most frequent side effects are drowsiness, nausea, vomiting and phlebitis.

I have been informed that most patients remain drowsy or sleepy following their surgery for the remainder of the day. Since anesthetics and other medications may cause drowsiness and incoordination, which can be enhanced by the use of alcohol and other drugs, I have been advised to abstain from their use until completely recovered from the effects of anesthesia and prescription medications. Additionally, I have been advised that patients receiving anesthesia should not operate any vehicle or hazardous device or make any major decisions for at least twenty-four (24) hours, or until completely recovered from the effects of anesthesia and prescription medications. Parents are advised of the necessity for direct parental supervision of children for 24 hours following their anesthesia.

I understand that anesthetics and other medications may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. Vasudeva of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For the similar reasons, I understand that I must inform Dr. Vasudeva if I am a nursing mother.

I acknowledge the pre-operative fasting regulations and attest that they were followed. The patient has had nothing by mouth for at least eight (8) hours immediately before the appointment, the only exception being clear liquids, which may have been taken up to two (2) hours prior to the appointment.

I have been fully advised of and completely understand the alternatives to intravenous sedation and general anesthesia, and accept all possible risks and consequences. I acknowledge the receipt of, and completely understand both pre-anesthesia and post-anesthesia instructions. It has been explained to me and I accept that there is no warranty or guarantee as to any result and or cure. I have had the opportunity to ask questions about my or my child's anesthesia and am satisfied with the information provided to me. I hereby consent to the administration of anesthesia during my or my child's treatment or surgery.

_____
Name (please print)

_____
Signature date (Relationship to patient if a minor)
(If patient is a minor: signature of guardian)

_____
Witness

Name of Patient:_____ Date:_____

1. I authorize the following procedures and treatment and acknowledge responsibility for all fees charged for treatment rendered whether covered by insurance or not.

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2. The nature and the purpose of the treatment, possible alternative methods of treatment, the risks involved, and the possible complications have been explained to me.

3. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

4. I consent to the administration of such anaesthetics as may be considered necessary or advisable.

5. I agree to follow instructions for before and after the procedure to the best of my ability for my own comfort and safety. I have been given the opportunity to ask questions and was satisfied with the responses given to me.

6. I have read and fully understand the above consent to treatment and that the explanations it referred to were in fact made to me and that the form was filled in prior to treatment.

I have read and understand the above:

_____ _____

Patient (Parent or Guardian) Signature Date

_____

If Parent or Guardian please print name

_____ _____

Witness Signature Date

_____

_____