Anxiolysis Consent

Commonwealth Dentistry

The purpose of this document is to provide an opportunity for patients to understand and give permission for Anxiolysis when provided along with dental treatment. Each item should be checked to acknowledge the opportunity for any questions to be answered, the procedure has been discussed.

I understand the purpose of Anxiolysis is to more comfortable receive necessary care. Anxiolysis is not required to provide the necessary dental care. I understand that Anxiolysis has limitations and risks and absolute success cannot be guaranteed.

I understand that Anxiolysis is a drug-induced state of reduced awareness and decreased ability to respond. Anxiolysis is not sleep. I will be able to respond during the procedure. My ability to respond normally returns when the effects of the sedative wears off.

I understand that my Anxiolysis wil be achieved by the following route:
_____ Oral Administration: I will take a pill approximately _____ minutes before my appointment. The sedational will last approximately ____ to ____ hours.

I understand that there are risks or limitations to all procedures. For sedation these include _____(oral sedation) Inadequate sedation with initial dosage may require patient to undergo procedure without full sedation or delay the procedure for another time.
____Atypical reaction to sedative drugs which may require emergency medication attention and or hospitalization such as altered mental states, physical reactions, allergic reactions, and other illnesses
_____ Inability to discuss treatment options with the Doctor should circumstance require a change in initial treatment plan.

If during the procedure a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgement is necessary. I understand that I have the right to designate the individual who will make such a decision on my behalf.

I have had the opportunity to discuss Anxiolysis and have my questions answered by qualified personnel including the doctor. I also understand that I must follow all the recommended treatments and instruction of my doctor.

I understand that I must notify the doctor if I am pregnant or lactating. I must notify the doctor if I have sensitivity to any medication, of my present mental and physical condition, if I have recently consumed drugs or alcohol and if I am presently on psychiatric mood altering drugs or other medications.

I will not be able to drive or operate machinery while taking oral sedatives for 24 hours. After the procedure I understand I will need to have arrangement for someone to drive me to and from my dental appointment while taking oral sedatives.

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I hereby consent to Anxiolysis in conjunction with my dental care.

Signature of Patient/Guardian	Date	Witness