Ambulatory Dental Anesthesia OF MONTANA

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Informed Consent for Deep Sedation and General Anesthesia

Patient name: _____ Case No. _____ Date: ____/____/____

Your dentist has consulted a dentist anesthesiologist to assist with dental treatment for yourself, your child or other dependant individual for whom you are legally empowered to make health care and financial decisions. Like any dental procedure, anesthesia is not guaranteed. It is the responsibility of your dentist anesthesiologist to inform you of the risks and complications of anesthesia in terms you can understand. It is your responsibility to ask questions when you are uncertain, in doubt, or explanations are not clear to your satisfaction. Following these conversations, you must decide whether or not to proceed with the recommended course of treatment.

Most dental procedures are elective in nature and can be accomplished with local anesthesia (the use of drugs like "novocaine" or "lidocaine", or "to get numb"). However, some children and/or physically or mental challenged adults are uncooperative, or are unable to tolerate dental procedures despite the use of local anesthesia. Finally, certain individuals may not tolerate dental procedures and may choose to be sedated in addition to local anesthetics.

Because of this, general anesthesia has been recommended to complete the necessary treatment. It is an effective tool that, when used along with or in stead of local anesthesia, favorably helps these patients receive treatment.

General anesthesia is accomplished by using drugs which are given through a vein, or by inhaling into the lungs. During the procedure the following parameters are closely monitored by the dentist anesthesiologist:

1. Heart rate and rhythm (to assess the heart's overall function)
2. Blood pressure
3. Body temperature
4. Breathing
5. Amount of oxygen in the blood

Common negative consequences due to receiving general anesthesia drugs include, but are not limited to:

1. Inflammation (redness & swelling) and/or infection at the IV site
2. Nose bleeds
3. Sore nose and/or throat
4. Injury to the eyes, lips, or teeth
5. Allergic reaction to medications used

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In rare instances, general anesthesia can result in brain injury or death. To fully evaluate and reduce these risks, it is important that a thorough, complete medical history be provided to Dr. Klise.

After reading this consent and discussing the anesthesia plan with Dr. Klise, I agree that:

1. I have completed a medical history form which is, to my knowledge, accurate and current for the individual in question.
2. I have provided Dr. Klise with a current health history from this patient's physician.
3. I have reported any medications that will be or have been taken to Dr. Klise.
4. Dr. Klise has informed me of the risks and benefits of general anesthesia, and questions have been encouraged and answered to my satisfaction.
5. At the discretion of Dr. Klise, the procedure may be terminated at any time due to concerns for this individual's safety.

_____ The patient receiving general anesthesia has not had any food or drink since ___/ ___/ ___ at _____ ___AM ___PM (time and date) *

_____ I have informed Dr. Klise of any medications this individual has taken prior to the procedure.*

_____ I have received, read, and understand both the Preoperative and Postoperative Instructions for Anesthesia prior to the procedure. Questions have been encouraged and answered to my satisfaction.*

_____ I have had the opportunity to review this Informed Consent for Deep Sedation and General Anesthesia, questions were encouraged, and I was given answers to my satisfaction.

_____ Should I have any questions or recognize any problems with the patient following anesthesia, I will call Dr. Klise at (406) 529-2612 immediately.*

*To be initialed at time of appointment

I consent to have Dr. Klise provide anesthesia for myself, my child or dependant individual for whom I am legally empowered to make health care decisions.

_____   _____
Patient or Guardian signature   Patient, Parent, or Legal Guardian printed

Date: ____/____/____   Time: _____ ___AM ____PM

_____
Terry Klise, D.D.S.

_____   _____
Witness (printed)   Witness signature