Consent for Treatment under Sedation

Patient details:

Surname ____________________

Forenames ____________________

Address ____________________

____

____

Date of Birth ____________ Weight ________ Height ________ Male ☐ Female ☐

PATIENT / PARENT / GUARDIAN

- Please read this form carefully
- If there is anything that you don't understand about the explanation, or if you want more information, you should speak to the dentist or the doctor
- Check that all the information on the form is correct

I am the patient / parent / guardian

I agree to what is proposed and which has been explained to me by the doctor / dentist named on this form

I understand that any procedure in addition to the treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons

I have told the doctor or dentist about any additional procedures that I would NOT wish to be carried out straightaway without my having the opportunity to consider them first.

Patient's Signature ____________________ Date ____________

Name and address *(if the person signing is not the patient):* ____________________

____

____

Dentist *(this part to be completed by the dentist)* Dentist's name ____________________

DESCRIBE THE OPERATION, INVESTIGATION OR TREATMENT

I confirm that I have explained the treatment and the sedation proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Dentist's Signature ____________________ Date ____________

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CONFIDENTIAL MEDICAL HISTORY

Please look at the following list, and **tick any of the conditions that might apply to you.**

1. Medical conditions

		YES	NO	If YES please give details:
1.1	Heart attacks, angina, strokes?	☐	☐	
1.2	Rheumatic fever, heart "murmurs", heart operations?	☐	☐	
1.3	Been told you have a heart complaint?(Palpitations)	☐	☐	
1.4	High blood pressure?	☐	☐	
1.5	Difficulty with breathing, or lung operations?	☐	☐	
1.6	Asthma or similar problems?	☐	☐	
1.7	Ever given systemic steroid treatment?	☐	☐	
1.8	Muscle problems (myopathy, dystrophy, paralysis)?	☐	☐	
1.9	Neurological (nerve) diseases ("neuropathies" MS etc)?	☐	☐	
1.10	Diabetes?	☐	☐	
1.11	Epilepsy (Fits or Convulsions)?	☐	☐	
1.12	History of Thrombosis or Embolism? (Bloodclots)	☐	☐	
1.13	Abnormal haemoglobin (sickle-cell, thallasaemia etc)?	☐	☐	
1.14	Have you ever bled excessively from cuts or tooth extractions?	☐	☐	
1.15	Are you taking anticoagulant treatment? (anti clotting, e.g. aspirin, warfarin)	☐	☐	
1.16	Gastro-intestinal ulcers or serious indigestion?	☐	☐	
1.17	Do you have any kidney problems?	☐	☐	
1.18	Jaundice, hepatitis, or liver problems?	☐	☐	
1.19	**Allergies to medicines or tablets?** (Penicillin, etc)	☐	☐	
1.20	**Allergies to anything else?** (Eggs, elastoplast, latex, etc)	☐	☐	
1.21	Severely over or underweight?	☐	☐	
1.22	Are you attending or receiving treatment from a Dr, hospital, clinic or specialist?	☐	☐	
1.23	ANY other medical problems not listed above? (HIV etc)	☐	☐	
1.24	FEMALE PATIENTS: are you, or might you be pregnant?	☐	☐	
	Are you breast feeding?	☐	☐	

2. Major operations, YES ☐ NO ☐

if YES please state what operations:

3. Are you taking or receiving any tablets, medicines, or treatments now? (including herbal medication) YES ☐ NO ☐

if YES please write them down here:

4. Have you or any member of your family ever had a reaction of any sort to anaesthetics? YES ☐ NO ☐

if YES describe what happened:

5. Innoculations / immunisations in the last 7 days? YES ☐ NO ☐

please say what and when

6. Last dental treatment ..../........../..........

Was treatment carried out under local anaesthetic ☐ Conscious Sedation ☐ General anaesthetic ☐

Any further information concerning your medical history. If there is anything that you would like to discuss in confidence with the doctor, but prefer not to write down please tick this box. You should at least tell the doctor if you drink regularly, smoke heavily or use other drugs socially or for pleasure. ☐

ANAESTHETIST name: ____________________

I confirm that I have read this medical history, and undertaken any further questioning or examination as appropriate. I have explained to the patient the proposed method, and the options for anaesthesia and sedation available to them, in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature ____________________ Date ____________________

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