FREE DENTISTRY - Intravenous Conscious Sedation Dental Program

We are currently accepting patients for the IV Conscious Sedation Dental Program. We are running the Dental IV Conscious Sedation Program at the University of Alberta in December, February, and May of every year.

In this program, patients will be sedated for dental care. Patients will have **sedatives administered**, and **will be conscious and able to talk through the procedure**, but are kept relaxed and pain free. This program is ideal for healthy **ADULT** patients without any contraindicative medical conditions, not pregnant, who are not on any contraindicative medication, and tend to be somewhat anxious of dental treatment. You do not necessarily have to be an anxious patient to qualify for this program, it is open to anyone who is eligible as a patient. An accurate measure of height and weight is required as part of the screening process for this program. A patient's BMI must be below 35 at the time of screening and treatment in order to proceed with the treatment. Due to provincial regulations a BMI >35 at any time makes a person ineligible for this program.

Care is provided by licensed dentists who are participating in this program for additional training, and to demonstrate clinical competency and proficiency in these sedation techniques. These participants have all passed pre-requisite program material and have practiced for a number of years.

Dental Care will be provided free of charge and will only be as extensive as conditions permit. Each patient's response to sedation varies, and therefore the amount of work to be completed is not assured. Care will typically be restricted to simple cleanings, fillings, and extractions. Root canal treatment is not provided as part of this program. Some patients may be able to come on multiple appointments to complete as much treatment as possible.

Patients must be willing to receive IV Sedation each time for every appointment, and make arrangements for an able bodied person **to be discharged to, and to accompany them back home**, on the dates of the treatment.

Patients will be required to attend a pre-screening appointment prior to any potential sedation and dental treatment appointments to determine eligibility. Once pre-screened, patients must be available for appointment dates on at least one of the days during our 5 day clinical sessions, which are run in December, February and May. NOTE: You **DO** require an accompanying person for the sedation appointment.

In order to facilitate patient screening and to be a part of this program, we require an email indicating the person's interest in this program, their full name, an email address, the complete mailing address including postal code, cell / daytime and evening contact numbers. Emails are to be sent to the program administrator at dentce@ualberta.ca . Alternatively, people can call 780-492-1894, although email is strongly preferred.

This program is not exclusive and can include any family members or friends that are made aware of the program and who contact our office accordingly. This letter and the applicable forms may be provided directly to any interested patients.

Please completely fill out and return the forms included in the following pages via the methods indicated below. Eligible interested patients will be contacted for scheduling, screening, and for additional information if required.

IMPORTANT: FORMS TO BE RETURNED PRIOR TO PRE-SCREENING APPOINTMENT SCHEDULING

If applicable, please include a note with any medication you are currently on, or may have been on in the past 6 months (including dosage and frequency, and purpose of medication) along with the medical history form. Please attach this information on a separate sheet of paper if required.

PLEASE NOTE THAT INCOMPLETE FORMS WILL NOT BE REVIEWED - ENSURE THAT ALL THE REQUIRED INFORMATION IS FULLY FILLED OUT, INCLUDING YOUR ACCURATE HEIGHT AND WEIGHT, AND ANY APPLICABLE MEDICATION INFORMATION.

Please make sure to completely and accurately fill out these forms and return:

VIA SECURE EMAIL (Brightsquid): Please email us with the phone number to reach you at, and a staff person will contact you for information (specifically the patients Date of Birth, email address) to securely send the forms for filling out and return via Brightsquid email.

By Fax: Fax the completed forms to 780-492-8973 – please email / call us to confirm receipt of the fax

By Mail to the address below:

Continuing Dental Education
Faculty of Medicine and Dentistry
5-566 Edmonton Clinic Health Academy
University of Alberta
11405 87 Avenue
Edmonton, AB T6G 1C9

UNIVERSITY OF ALBERTA

Chart #: | | | | | | |

FACULTY OF MEDICINE & DENTISTRY

SCHOOL OF DENTISTRY

DATE: _____

PATIENT 'S REGISTRATION INFORMATION

Mr.
Mrs.
Ms,
Child

Last Name: _____ **Given Name:** _____

Address: _____

_____ **Postal Code:** _____

Telephone (Home): _____ **Telephone (Business):** _____

Cell Phone: _____ **Email:** _____

Alberta Personal Health Number: _____ **DOB:** _____

Dental Insurance Information: **Insurance Company:** _____

Group/Policy #: _____ **I.D./Certificate #:** _____

Cardholder Name: _____ **Cardholder DOB:** _____

Second Carrier Information: **Insurance Company:** _____

Group/Policy #: _____ **I.D./Certificate #:** _____

Cardholder Name: _____ **Cardholder DOB:** _____

Physician's Name: _____ **Physician Phone #** _____

Physician's Address: _____

Emergency Contact: _____ **Phone #:** _____

Relationship to patient: _____

Parent/Guardian Name: _____ **Phone #:** _____
(If child under 16)

Parent/Guardian Address: _____
(If different than above)

THE GOVERNORS OF THE UNIVERSITY OF ALBERTA and the FACULTY OF MEDICINE AND DENTISTRY

Dental Clinics – under the authority of the University

CONSENT TO DIAGNOSIS AND TREATMENT PLAN

PLEASE READ THIS DOCUMENT CAREFULLY!

CONSENT TO DIAGNOSIS AND TREATMENT PLAN

I understand that The Governors of the University of Alberta and the Faculty of Medicine and Dentistry, their officers, board members, agents, employees, students, volunteers, servants and representatives (the "University") operate dental clinics as part of teaching and research and that treatment may be provided by one or more students within these programs.

I understand that the students performing work on me are not licensed or practicum dentists **/** dental hygienists but are registered University students under the supervision of the appropriate licensed practitioner.

I understand that the residents performing work on me are licensed dentists through Alberta Dental Association and College (ADA+C) and are registered postgraduate dental education residents under the direct or indirect supervision of the appropriate licensed practitioner.

I hereby consent to and authorize the University to perform diagnostic services, administrate anesthetics and medications as deemed necessary and dental treatment is required by me or my child.

DEVELOPMENT OF TREATMENT PLANS AND FINANCIAL COSTS

I understand that during treatment I or my child may have "Consent to Treatment" forms for treatment over and above normal dental care prepared and presented to me for review. These treatments plan recommendations and costs will be explained to me in detail.

I acknowledge that **1** will be required to sign (for myself or my child) a "Consent to Treatment" form prior to the commencement of any of these treatments acknowledging which treatment plan I have chosen for myself or my child and the anticipated financial cost of the plan to me.

CONSENT TO PUBLICATION OF PHOTOGRAPHS AND OTHER RECORDS

The University may deem all or any portion of my dental records (or my child's), including charts, casts, radiographs, and photographs, to be of benefit in dental education and science. For research involving human subjects, full approval will be received through the appropriate Human Ethical Board prior to the start of the research study. The individual identification of human subjects used for research will be kept in strictest confidence and not identifiable from material used.

I hereby consent, for myself or my child, to the publication or republication of such dental records and information, either separately or in connection with each other, in professional journals or dental books or to their use for any other purpose, which the University may deem proper in the interest of dental education.

I acknowledge and understand that in any such publication or use, I or my child, will not be identified by name as the patient with the exception that I or my child may be identified to any accreditation body as required by, and only to the limited extent required by, such accreditation body.

DESCRIPTION OF RISKS

I acknowledge that I am aware there are risks associated with or related to the dental treatment to be received by me or my child and these risks include, but are not limited to:

- reactions to anesthetics and medications given during treatment (including paresthesia);
- dangers associated with radiation from x-rays;
- sore, irritated and bleeding gums due to dental procedures used in cleaning teeth;
- injuries, irritations, sensitivity or damages to the mouth, gums, jaw, muscles, bone and teeth due to dental procedures used during treatments including inconvenience or further treatment due to any of these reasons;
- Infections occurring during and after dental treatment;
- discomfort resulting from dentures and sore, irritated and bleeding gums;
- Unmet **/** unresolved aesthetics expectations.

CONSENT TO TEST

In the event of inadvertent possible transmission of infectious material to a person rendering treatment to me or my child, I understand and agree to comply to testing of my, or my child's, blood for determination of transmissible diseases.

TERMINATION OF TREATMENT

The University reserves the right, in its sole discretion, to terminate treatment of any patient for any reason whatsoever. In the event the treatment becomes more complex than originally anticipated the University may terminate treatment and refer me or my child to an appropriate licensed practitioner to continue and/or complete treatment. I hereby accept and acknowledge that the University has the right to terminate treatment.

Protection of Privacy - By signing below, I consent to having the information in this document collected by The Governors of the University of Alberta, and the Department of Dentistry within the Faculty of Medicine and Dentistry. The personal information requested on this form is collected under the authority of Section 33(c) of the *Alberta Freedom of/n formation and Protection of Privacy Act.* to receive dental treatment within one of our Dental Clinics, and it will be protected under Part 2 of that *Act.* It will be used for the purpose of implementing this Assumptions of Risk and Indemnity Agreement. Direct any questions about this collection *to: Insurance & Risk Assessment, University of Alberta, #1004 College Plaza, Edmonton, Alberta, Canada, T6G 2C8, (780) 492-8875*

ACKNOWLEDGMENT

I acknowledge that I have read and understood this Agreement that I appreciate and accept the risks associated with dental treatment and that I have executed this Agreement voluntarily. If my child is to receive the dental treatment, I am executing this Agreement as the parent or legal guardian of this child.

Print Name

Signature

Date

School of Dentistry Oral Health Clinic

Adult Patient Medical History (COHRI) Worksheet

Circle either **Y** (YES) or **N** (NO) or **DK** (DON'T KNOW) to the following questions and provide details as required.
All information will be kept strictly confidential.

Patient Name: _____
Last First MI

Physician's Name: _____ Physician's Phone Number: _____

Physician's Address: _____ Date of last visit to physician: _____

I give consent for the School of Dentistry Oral Health Clinic to consult with my physician(s), if required: ☐ YES ☐ NO

PATIENT EVALUATION

Height (ft, in): _____ Weight (lbs): _____ Temperature (°C): _____

Do you have any of the following diseases or problems? If **YES**, check all that apply: **Y N DK**

- ☐ Active tuberculosis
- ☐ Persistent cough greater than 3 weeks in duration
- ☐ Cough producing blood
- ☐ Been exposed to anyone with tuberculosis

GENERAL MEDICAL INFORMATION

Are you now, or have you been in the past year, under the care of a physician? **Y N DK**

Do you require pre-medication prior to receiving any dental treatment? **Y N DK**

Have you had any serious illness, operation, or been hospitalized in the past 5 years? **Y N DK**

If **YES**, how long ago?

- ☐ 0-6 months
  - Specify illness or problem: _____
- ☐ 6-12 months
  - Specify illness or problem: _____
- ☐ 1-2 years
  - Specify illness or problem: _____
- ☐ 2-5 years
  - Specify illness or problem: _____

Have you had an organ transplant? If **YES**, please specify: **Y N DK**

- ☐ Heart
- ☐ Kidney
- ☐ Liver
- ☐ Lung
- ☐ Other: _____

Have you had open-heart surgery? If **YES**, please specify: **Y N DK**

- ☐ Valve
- ☐ Bypass (CABG)
- ☐ Other: _____

Have you had an orthopedic total joint replacement? (e.g. hip, knee, elbow, finger) **Y N DK**

Have you ever had any radiation therapy or chemotherapy for a growth, tumor or other condition? **Y N DK**

If **YES**, please specify:

- ☐ Radiation
  - explain: _____
- ☐ Chemotherapy
  - explain: _____

In the last 2 years, have you taken or are you now taking steroids? (e.g. Cortisone) **Y N DK**

If **YES**, specify steroid medication(s), dosage, frequency, length of period taken, and when discontinued (if no longer taking):

MEDICATION	DOSAGE	FREQUENCY	LENGTH OF PERIOD TAKEN	WHEN DISCONTINUED
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you taken, are you taking or are you scheduled to begin taking oral bisphosphonates? **Y N DK**
(Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), or Tiludronate (Skelid))

Have you taken, are you taking or are you scheduled to begin taking intravenous bisphosphonates? **Y N DK**
(Clodronate (Bonefos), Pamidronate (Aredia) or Zoledronic Acid (Reclast, Zometa))

TOBACCO/CANNABIS USE

Do you use or have you used tobacco (smoking, snuff, chewing tobacco, bidis) or cannabis? **Y N DK**

Past (former user/smoker - greater than 1 year without use/smoking)

- ☐ Cigarettes/cigars
  - amount smoked per day: _____
  - years without smoking: _____
- ☐ e-Cigarettes
  - amount smoked per day: _____
  - years without smoking: _____

☐ Pipe
- amount smoked per day: _____
- years without smoking: _____

☐ Cannabis
- amount smoked per day: _____
- years without smoking: _____

☐ Snuff
- amount smoked per day: _____
- years without smoking: _____

☐ Chewing tobacco
- amount smoked per day: _____
- years without smoking: _____

☐ Bidis
- amount smoked per day: _____
- years without smoking: _____

Currently

☐ Cigarettes/cigars
- specify amount per day: _____
- for how many years? _____
- how interested are you in stopping? _____

☐ e-Cigarettes
- specify amount per day: _____
- for how many years? _____
- how interested are you in stopping? _____

☐ Pipe
- specify amount per day: _____
- for how many years? _____
- how interested are you in stopping? _____

☐ Cannabis
- specify amount per day: _____
- for how many years? _____
- how interested are you in stopping? _____

☐ Snuff
- specify amount per day: _____
- for how many years? _____
- how interested are you in stopping? _____

☐ Chewing tobacco
- specify amount per day: _____
- for how many years? _____
- how interested are you in stopping? _____

☐ Bidis
- specify amount per day: _____
- for how many years? _____
- how interested are you in stopping? _____

ALCOHOL USE			
Do you drink alcoholic beverages?	**Y**	**N**	**DK**
If **YES**, are you alcohol dependent?	**Y**	**N**	**DK**

DRUG USE			
Do you use prescription or street drugs or other substances for recreational purposes?	**Y**	**N**	**DK**

If **YES**, check all that apply:

Past: ☐ Cocaine ☐ Ecstasy ☐ Heroin ☐ Cannabis ☐ Methamphetamine ☐ Oxycontin
☐ Other: _____

Currently: ☐ Cocaine ☐ Ecstasy ☐ Heroin ☐ Cannabis ☐ Methamphetamine ☐ Oxycontin
☐ Other: _____

If **YES**, are you drug dependent?	**Y**	**N**	**DK**

FEMALES ONLY			
Are you pregnant? If **YES**, number of weeks: _____	**Y**	**N**	**DK**
Are you nursing?	**Y**	**N**	**DK**
Are you taking birth control pills, fertility drugs or hormonal replacement?	**Y**	**N**	**DK**

If **YES**, check all that apply: ☐ Birth Control Pill ☐ Fertility Drugs ☐ Hormonal Replacement

MEDICATIONS			
Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications? (prescription, over the counter, diet supplements, vitamins, natural or herbal)	**Y**	**N**	**DK**

MEDICATION	**DOSAGE**	**FREQUENCY**	**REASON**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

Are you allergic to or have you had a reaction to any of the following? If **YES**, check all that apply: **Y N DK**

- ☐ Local anaesthetics (Lidocaine / Epinephrine)
  - Reaction: _____
- ☐ Penicillin
  - Reaction: _____
- ☐ Sulfa drugs
  - Reaction: _____
- ☐ Other antibiotics
  - Specify: _____
  - Reaction: _____
- ☐ Codeine or other narcotics
  - Reaction: _____
- ☐ Aspirin
  - Reaction: _____
- ☐ Hay fever / seasonal (allergic rhinitis)
  - Reaction: _____
- ☐ Metals / Jewelry
  - Reaction: _____
- ☐ Food
  - Specify: _____
  - Reaction: _____
- ☐ Iodine
  - Reaction: _____
- ☐ Latex (rubber)
  - Reaction: _____
- ☐ Other / other medication(s)
  - Specify: _____
  - Reaction: _____

MEDICAL CONDITIONS

Do you have or have you had any of the following diseases, problems, or symptoms? **Y N DK**

If **YES**, check all that apply and provide details as required:

☐ **Heart / Blood Pressure Problem**

- ☐ Rheumatic Fever / Rheumatic Heart Disease
- ☐ Infective Endocarditis
- ☐ Artificial Heart Valves
- ☐ Congenital heart defect
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Angina (chest pain)
- ☐ Heart attack
- ☐ Heart failure
- ☐ Coronary heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Arrhythmia (irregular heart beat)
- ☐ Shortness of breath
- ☐ Swelling of the ankles
- ☐ Pacemaker
- ☐ Implantable defibrillator
- ☐ Other: _____

☐ **Respiratory / Lung Problem**

- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Tuberculosis
  - ☐ Active
  - ☐ Latent
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Persistent cough
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Other: _____

☐ **Diabetes / Endocrine Disorder**

- ☐ Type I Diabetes
  - ☐ Most recent HbA1c results: _____
- ☐ Type II Diabetes
  - ☐ Insulin required
  - ☐ Most recent HbA1c results: _____
- ☐ Thyroid problems
  - ☐ Hypothyroidism
  - ☐ Hyperthyroidism
- ☐ Other: _____

☐ **Kidney / Urinary Disorder**

- ☐ Renal failure/insufficiency
- ☐ Dialysis
- ☐ Frequent urination
- ☐ Other: _____

☐ **Cancer or Tumors**

- ☐ Malignant
  Location: _____
- ☐ Benign
  Location: _____

☐ **Neurologic / Nerve Problem**

- ☐ Stroke
- ☐ TIA (Transient Ischemic Attack)
- ☐ Seizures / Epilepsy
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Neuropathies
- ☐ Dementia / Alzheimer's (memory loss)
- Headache
- ☐ Fainting or dizzy spells
- ☐ Feeling of tingling or numbness
- ☐ Psychiatric disease / Mental health disorder
  - ☐ Bipolar / Manic depression
  - ☐ Schizophrenia
  - ☐ Depression
- ☐ ADD / ADHD (Attention Deficit Disorder)
- ☐ Feelings of anxiety
- ☐ Feelings of depression
- ☐ Other: _____

☐ **Blood / Hematologic Disorder**

- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Sickle cell trait
- ☐ Bruise easily
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Bleeding disorders
  - ☐ Hemophilia
  - ☐ Other: _____
- ☐ Other: _____

☐ **Stomach / Intestine / Liver Disorder**

- ☐ Cirrhosis / Chronic hepatitis
- ☐ Jaundice (skin/eyes turn yellow)
- ☐ Hepatitis
  - ☐ A
  - ☐ B
  - ☐ C
  - ☐ D
  - ☐ Other: _____
- ☐ Heartburn
- ☐ Acid reflux (GERDS)
- ☐ Ulcers
- ☐ Crohn's disease
- ☐ Other: _____

☐ **Muscle / Bone / Connective Tissue Disorder**

- ☐ Arthritis
  - ☐ Rheumatoid
  - ☐ Osteoarthritis
  - ☐ Other: _____
- ☐ Osteoporosis
- ☐ Gout
- ☐ Temporomandibular joint disorder
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Other: _____

☐ **Infectious Disease**

- ☐ HIV
- ☐ AIDS
- ☐ STI (Sexually Transmitted Infection)
  - ☐ Syphilis
  - ☐ Gonorrhea
  - ☐ Chlamydia
  - ☐ Genital herpes
  - ☐ Human papillomavirus
- ☐ Cold sores
- ☐ Other: _____

☐ **Head / Eye / Ear / Nose / Throat Problem**

- ☐ Vision problems
- ☐ Glaucoma
- ☐ Hearing impairment
- ☐ Other: _____

☐ **Dermatologic / Skin Problem**

- ☐ Specify: _____

☐ **Eating Disorder**

- ☐ Bulimia
- ☐ Anorexia
- ☐ Other: _____

Do you have any other problem, disease or condition not listed above? **Y N DK**
If **YES**, please specify: _____
_____

UNIVERSITY OF ALBERTA
FACULTY OF MEDICINE & DENTISTRY
School of Dentistry

DENTAL HISTORY

(Please answer or check where appropriate)

GENERAL INFORMATION

What dental condition concerns you at present? _____

_____

Is this your child's or your first visit to the dentist/dental hygienist? YES ☐ NO ☐

Date of last dental office visit: _____

What was it for? Check Up ☐ Filling ☐ Toothache ☐ Cleaning ☐ Other ☐

Have you ever had a bad experience during dental treatment? YES ☐ NO ☐

If yes, was there: Fainting ☐ Bleeding ☐ Reaction to anesthetic ☐ Other ☐

Have you ever had any of the following treatments? (please check)

Root Canal ☐ Orthodontics (braces) ☐ Periodontics (Gum) ☐ Dental Hygiene ☐

Crowns ☐ Check-up ☐ Filling ☐ Implants ☐

Are you satisfied with your previous dental treatment? YES ☐ NO ☐

Are you aware of any swelling, soreness, rough areas, ulcers, erosions or colour changes in your mouth? YES ☐ NO ☐

Have you ever noticed: Bleeding gums ☐ Receding Gums ☐ Sore Gums ☐

When did you last have your teeth cleaned? _____

Do you brush? YES ☐ NO ☐ How often? _____

Do you floss? YES ☐ NO ☐ How often? _____

Have you ever had professional instruction on mouth care? YES ☐ NO ☐

Are your teeth sensitive to: Heat ☐ Cold ☐ Brushing ☐ Chewing ☐ YES ☐ NO ☐

Does food catch between your teeth? YES ☐ NO ☐ If so, where? _____

Do you like the way your teeth look? YES ☐ NO ☐

Do any of your teeth feel loose? YES ☐ NO ☐

Are there any new spaces between any teeth? YES ☐ NO ☐

Do you (or the patient, if child) have any habits that involve your mouth? YES ☐ NO ☐

(please check all that apply)

Grinding ☐ Cheek Biting ☐ Lip Biting ☐ Clenching ☐

Mouth Breathing ☐ Tongue Thrusting ☐ Thumb Sucking ☐ Going to bed w/Bottle ☐

Holding Pins ☐ Biting Nails ☐

UNIVERSITY OF ALBERTA
FACULTY OF MEDICINE & DENTISTRY
School of Dentistry

DENTAL HISTORY

(Please answer or check where appropriate)

PAIN/DISCOMFORT

Do you experience pain or difficulty when you:

Yawn ☐ Chew ☐ Speak ☐ Swallow ☐ YES ☐ NO ☐

Do you have sore jaw muscles? YES ☐ NO ☐

Do you have clicking or popping sounds in your jaw? YES ☐ NO ☐

Do you have pain in front of your ears, temples or cheeks during chewing? YES ☐ NO ☐

Do you have frequent headaches? YES ☐ NO ☐

Does your bite feel uncomfortable or unusual? YES ☐ NO ☐

Does your jaw get “stuck”, “locked” or “go out”? YES ☐ NO ☐

Have you had a recent injury to your head, neck or jaw? YES ☐ NO ☐

Have you previously been treated for a jaw joint problem? YES ☐ NO ☐

If yes, when? _____

Do you wear a splint? YES ☐ NO ☐

FOR PATIENTS WITH REMOVABLE DENTURES:

Do you have:

☐ Complete Upper Dentures ☐ Complete Lower Dentures

☐ Partial Upper Dentures ☐ Partial Lower Dentures

How long have you had your current dentures? _____

How many dentures/partials have you had? _____

Why were your teeth removed? _____

Do you wear your dentures/partials all the time? YES ☐ NO ☐

Do you clean your dentures/partials? YES ☐ NO ☐

How often do you clean your dentures/partials? _____

Do you have any problems wearing your dentures/partials? YES ☐ NO ☐

Comments: _____

_____

_____

_____

Medical/Dental histories must be updated every 6 months

IV CONSCIOUS SEDATION FREE DENTAL PROGRAM

Thank you for your interest in being a patient for our Intravenous (IV) Conscious Sedation Free Dental Program, and for returning your patient forms. In order to proceed with your screening and potential treatment, please **CAREFULLY READ ALL THE FOLLOWING INFORMATION.** Please initial in the spaces where indicated with a line (_____) to provide your acknowledgement, understanding, and consent. This confirms that you have carefully read and understood the pertinent information, accepted the conditions and risks, and will adhere to the rules and guidelines provided for your safety and treatment. Appointments will not be booked, nor any treatment provided until such time as the FULLY signed and completed document is received back at our office. If you are unable to read or understand this document please review it with an interpreter, and they should sign it as your witness.

You will have received a detailed program information letter with your patient forms, which is included again at the end of this document for your reference. Should you have any questions following the review of this information, and prior to or after signing, please feel free to contact us via email at **dentce@ualberta.ca** or call **780-492-1894** and we would be happy to discuss this with you. If you determine that you do not wish to proceed with treatment, please inform us via email so that we are able to make note accordingly.

The purpose of this letter is to familiarize you, the patient, with the program, and to make you aware of the programs risks, options, rules and requirements. You may be invited to come in prior to your appointment for an in-person screening.

Description of Program

This course is designed as a certification program for licensed practicing dentists, who are working to receive their certification to provide simultaneous Intravenous (IV) conscious sedation and dentistry. They need to see 21 patients and as a function of that, we are able to provide some free dentistry to patients who can benefit from it.

_____: **I understand that this is a certification program for licensed practicing dentists, and consent to my IV Conscious Sedation appointments being part of their training requirements.**

IV Conscious Sedation dentistry is the intravenous administration of a sedative agent. In this program we use either versed alone or versed and fentanyl in combination, through an IV in the hand or arm. Patients will be sedated to the level where they can still respond to questions, but they are nicely relaxed. We only use as much sedative as is required to get them relaxed.

_____: I understand and consent to receiving Conscious Sedation through IV, using versed alone or versed and fentanyl in combination if necessary.

_____: I understand that I will be conscious and responsive during the sedation and not put to sleep.

What To Expect At Your Appointment

Your visit is the same protocol whether you come in for 1 visit or 40. At the beginning of your appointment, you will be assigned to one of the dentists who will review your health history, medications, and health status. They are looking to see if you've had any sedation or operations before and how you tolerated them, any allergies or medications that could be a medical or safety issue. Overall we are determining your health status and looking for any risks to treatment. We need accurate answers to determine the risks of care appropriately. Please note that if you are coming in for multiple visits during one clinic, you may not be assigned to the same dentist.

_____: I understand and consent to reviewing my health history, medications, and health status along with providing information about prior sedations and operations at the beginning of every visit.

_____: I understand and will comply in providing accurate answers to determine my current health status.

Once the health history is reviewed, you will be set up with a blood pressure cuff, ECG leads, and pulse oximeter. We are looking to assess your health baseline status. Please note: If your baseline presents any signs of potential risk, this will be personally discussed with you and one of the program instructors. They will assess whether to proceed with sedation, or if it is too high of a risk. If deemed too high risk, the instructor will provide information on what medical steps you may need to take.

_____: I understand that my health baseline status will be assessed, and that if any potential risks are noted, that the sedation may not proceed.

The dentist will then talk to you about your dental needs, and determine what they will work on for that visit. For the purpose of this program, we provide cleanings, fillings, or simple extractions. We do not provide any root canals, crowns, dentures etc. Only basic dental procedures are provided. Dental procedures are only completed as discussed, but the dentist and University reserve the right to change treatment plans, treatment options, and the amount of care as necessitated by time, or the condition of the patient. We do not guarantee any specific care, or absolutes with treatment plans.

_____: I understand that the only dental procedures provided are cleanings, fillings, and simple extractions.

_____: I understand and consent to receiving the treatment as planned on a per visit basis, as recommended by my assigned dentist.

_____: I understand and consent to the dentist or University reserving the right to change any treatment plans, options, or care as necessary during my appointment.

_____: I understand that if the dentist cannot finish all treatment, I may have to go to a regular dentist or clinic and pay for any remaining treatment.

After treatment has been confirmed the dentist will start the IV in your hand or arm. Once everything is set up, then the dentist will start the sedation, and get you to a point where you are comfortable. Please note: as this is a teaching clinic, the dentists are learning how to place IV's, so be aware that they may take a few tries to insert the IV.

_____: I understand that this is a teaching clinic and that the dentist may take multiple attempts to insert the IV.

Sedation Risks

The outline of the risks associated with sedation is done so that you can understand the inherent risks of any procedure you are receiving, and what could potentially happen. This is meant to educate you, not intimidate or concern you.

Standard common dental risks include the possibility of damage or loss to a particular tooth, associated teeth and tissue. This risk is described as the common risk that you can experience with any dental procedure. Examples are if we are working on a tooth with a cavity that requires a filling, the tooth may fracture and require eventual extraction, or the filling may be deep and it requires a root canal, or other treatment. A tooth on extraction may cause damage to neighboring teeth. The gum tissue surrounding the tooth receiving a filling or extraction may be tender after treatment.

_____: I understand that there are common dental risks associated with any procedure.

Sedation risks are those associated with the administration of the sedative agent itself, and the response that people can have to it. The drugs administered can cause allergic reactions, or a response that affects their heart, breathing, cognitive function, etc. Sedative risks also include an increased risk of aspiration.

_____: I understand that there are sedation risks associated with the drugs administered.

Sedation Rules

The sedation risks help highlight why following the rules outlined in the IV SEDATION DENTAL CLINIC PATIENT APPOINTMENT INSTRUCTIONS pages at the end of this consent document are so important. The rules are meant to help reduce risk to you and others. For example, the reason we ask you not to eat or drink prior to your appointment is because we want to reduce your risk of an adverse outcome. A certain percentage of people will get nauseous with the administration of a sedative agent, and as you are being sedated your cough reflex may be hampered. If this is the case and you get sick, you may bring up stuff that can end up back in your airway. You will be taking a trip to the emergency department, having a bad week and so will we. Please follow all rules outlined for the day before, day of, and after your procedure.

_____: I have read and agree to follow ALL rules outlined in the patient appointment instructions information sheet.

Appointment Delays

We are running a complex program that deals with many patients, who all respond differently to drugs and treatments. This can create issues with our "air traffic control" and scheduling. We do our best to keep running on schedule, but please be aware it is hard to anticipate how people may respond, and safety always comes first. We ask that your rides stay here or are very closely accessible. Please bear with us if we run into scheduling and appointment delays or cancellations.

_____**: I understand that my scheduled appointment may not always start on time.**

Program and Treatment Participation Options

Options regarding the program for participation are simple – they are participation or non-participation. If at any point you do not feel comfortable with the program or treatment, please inform one of the faculty and we can assist you with ending your appointment. The care is elective and we do not need to proceed with anything, should you not be comfortable with it.

_____**: I understand that if at any time I do not feel comfortable proceeding with the program or treatment, that I have the right to cancel and end my appointment, and / or participation in future clinics.**

ACCEPTANCE:

I hereby acknowledge receipt of the original document hereof, and accept the terms and conditions set forth within.

Patient Name:_____ Signature: _____

Date: _____

Witness / Interpreter Name: _____

Signature: _____

UNIVERSITY OF ALBERTA - IV SEDATION DENTAL CLINIC PATIENT APPOINTMENT INSTRUCTIONS

Should you be deemed an eligible patient following pre-screening, the instructions below MUST be followed.

THE DAY BEFORE YOUR PROCEDURE

1. **DO NOT** eat or drink anything **AFTER MIDNIGHT**, **this is EXTREMELY CRITICAL FOR YOUR SAFETY. Carefully review the detailed fasting guidelines on the next page and follow them accordingly.**

2. **DO NOT** drink any alcoholic beverages the day before your procedure

3. **DO NOT** chew gum or tobacco, suck mints or sip water after midnight

4. If you become ill before your appointment please notify us immediately.

THE DAY OF YOUR PROCEDURE

1. Please remove all facial makeup, fingernail polish and leave all jewelry and valuables at home

2. Wear clothing that will be loose and comfortable during and after your procedure

3. If you are taking any medication on a regular basis, please take them with a **SIP** of water in the morning (Just a sip of water for pills, NOT a glass of water)

AFTER YOUR PROCEDURE

1. You **MUST** be accompanied home by a responsible, able-bodied adult who can physically support you after your appointment, and can be contacted at anytime during and after your procedure. A responsible adult must be with you for the first 24 hours after your procedure.

2. You **MUST NOT** drive or travel home alone by bus or taxi.

3. **DO NOT** sign any important documents, drive or operate power tools or machinery for at least 24 hours.

4. **DO NOT** drink alcohol; take any sleeping pills or tranquilizers for at least 24 hours.

5. If you go to the hospital within 10 days of your dental appointment, the dental clinic must be notified.

UNIVERSITY OF ALBERTA
IV SEDATION DENTAL CLINIC PATIENT APPOINTMENT INSTRUCTIONS

Fasting Guidelines for IV Sedation Dental Appointments

Your appointment will be cancelled if these are not followed.

For appointments *before Noon (AM)*:

- **Eat as you normally do the day before your appointment.**
- **In the evening, drink 3 cups of apple juice or cranberry juice or a sports drink (none of these should be diet or low calorie – you are boosting your carbohydrate stores in your body so you will feel better).**
- **Eat and drink NOTHING after midnight - THIS IS CRITICAL FOR YOUR SAFETY!!**

For appointments *after Noon (PM)*:

- **Eat as you normally do the day before your appointment.**
- **In the evening, drink 3 cups of apple juice or cranberry juice or a sports drink (none of these should be diet or low calorie – you are boosting your carbohydrate stores in your body so you will feel better).**
- **Eat NOTHING after midnight - You may consume a very light breakfast (e.g. toast with jam) no later than SIX HOURS before the appointment (e.g. 7 am for a 1 pm appointment).**
- **The morning of your appointment you *should* drink 2 cups of apple juice or cranberry juice or a sports drink. You MUST finish drinking THREE HOURS before your appointment.**
- **Clear fluids* are good to drink no later than THREE HOURS before the appointment (e.g STOP DRINKING by Noon for a 3 pm appointment).**
  ***Clear fluids accepted are:
  - water
  - clear tea or black coffee (no cream, milk, or other whiteners)
  - clear fruit juice (apple juice, cranberry juice)
  - cola or other sodas
  - gatorade or powerade
  - jello