1. Relevant Medical History

Title, Forename, and Surname	
Date of birth:	
Mobile and Home Numbers:	
Email address:	
Occupation:	

MEDICAL HISTORY		**YES**	**NO**
CHEST/LUNG CONDITIONS	Chronic Bronchitis, Emphysema, Asthma, Shortness of Breath, other?		
	Please state:		
HEART/BLOOD CONDITIONS	Angina, high or low blood pressure, bleeding, pacemaker, stroke, other?		
	Please state:		
VIRUSES/INFECTIONS	Hepatitis, HIV, HPV, other?		
	Other (please state):		
EPILEPSY	Are you Epileptic?		
	Details?		
DIABETES	Do you have diabetes?		
	Details?		
CANCER(S)	Do you or have you had cancer(s)?		
	Details?		
HOSPITALISATIONS	*Have you been hospitalized in the last 2 years?*		
	Details?		
WARNING CARD	Do you carry a warning card?		
	Details?		
HABITS	How many cigarettes do you smoke per day?		
	How many units of alcohol per week?		
MEDICATION/SUPPLEMENTS	*Please list any medications or supplements you are taking…*		
ALLERGIES	*Please list any allergies that you have…*		
OTHER	*Please include anything else the dentist or sedationist should know…*		

Patient signature: _____

Date of signing: _____

2. Sedation Specific History

What is your height, weight and BMI?

Height:	Weight:	BMI:

Do you suffer from Sleep Apnoea, or have any neck movement or airway difficulties?

Do you use any recreational drugs?
(It is important the team know of any drugs that you might be taking before having IV sedation)

Have you had Sedation or General Anaesthetic previously?
(If so please give us a history and make us aware of any complications that arose)

Do you have or have you had any psychiatric conditions?
(Anxiety, depression, panic attacks, other)

Have you had any bad experience that you think we should be aware of?

Is there any chance you might be pregnant? Are you breastfeeding?

Do you have a pronounced gag reflex? Details?

Do you have any mobility issues or requirements?

Is there anything else that you feel the team should know?

DENTAL ANXIETY. Please score **EACH** question below using this scale:

Not anxious=1 **Slightly anxious=2** **Fairly anxious=3** **Very anxious=4** **Extremely anxious=5**

HOW WOULD YOU FEEL IF YOU WERE;
at your Dentist for TREATMENT TOMORROW?
sitting in the WAITING ROOM (waiting for treatment)?
about to have a TOOTH DRILLED?
about to have your TEETH SCALED AND POLISHED?
about to have a LOCAL ANAESTHETIC INJECTION in your gum, above an upper back tooth?

MDAS Score: _____
25

3. Consent

IV Conscious Sedation Informed Consent

A small cannula (plastic tube) is placed on the skin and a sedative drug or drugs are given that makes the patient relaxed and sleepy. This is NOT A GENERAL ANAESTHETIC. The aim is for the patient to be relaxed and comfortable during the treatment. Appropriate local anaesthesia will still be used when needed to avoid pain during the procedure. The patient may NOT REMEMBER anything afterwards. The patient will not be able to leave until appropriately recovered afterwards. The patient may be very tired, confused and uncoordinated afterwards.

CONSENT;

- I understand the dental treatment and the '*intravenous sedation'* that will be provided and the possible outcomes. I understand and have discussed the **benefits, risks** and alternatives to sedation
- I am aware of potential complications including; **drowsiness** (common), nausea and vomiting (rare), oversedation (rare) and the need to **abandon** the procedure (rare)
- I am aware that the **alternatives** include local anaesthesia only, inhalation sedation, general anaesthesia, hypnosis, and other therapies
- I have agreed and consented to appropriate **deviations** to treatment with the dentist, and outside of this I am aware a further sedation appointment would be needed in order to obtain consent beforehand.
- I understand that I **MUST NOT** drive a vehicle, ride a bicycle, operate machinery, drink alcohol, make any big decisions, or **HAVE ANY RESPONSIBILITES** for 24 hours (Including child care or pet care)
- I am aware that I should **NOT EAT OR DRINK FOR AT LEAST 2 HOURS** before my sedation appointment
- I am aware that I should arrange to be **OFF WORK THE DAY AFTER MY SEDATION**
- I am aware take my usual prescribed medicines should be taken unless directed otherwise by a doctor or dentist.
- I am aware that I should wear **short sleaved** and loose, comfortable clothing on the day of my sedation so that my arms can be accessed for blood pressure and medication
- I am aware that I should wear comfortable, **sensible shoes** (no heels or flip flops etc)
- I am aware that I should not wear nail varnish or fake **nails** on the day of sedation (this is to allow for oxygen monitoring)
- The journey home will be by **car** or taxi. I am aware that I cannot use public transport.
- I have arranged for a **RESPONSIBLE, ABLE BODIED, ABLE MINDED CHAPERONE** (over the age of 18) to accompany me to my appointment, escort me home with respect to my dignity and ensure they stay with me until at least the next morning and until I'm appropriately recovered. I understand that my escort must remain **within the practice** during my treatment
- The chaperone must have **NO other responsibilities** (including childcare) during my care
- The chaperone must make sure that I am not left alone and they must be with me overnight
- I have discussed, read, and understood all the information that has been provided. I have been given an opportunity to ask about all aspects of the above and have had all my questions answered fully. If I have any further questions, I will make sure to ask at the earliest opportunity
- The chaperone will have seen, read, and understood all the information that has been provided. They will have an opportunity to ask about all aspects of the above. If they have any further questions, we will make sure to ask at the earliest opportunity

Signature: _____ Date _____/_____/_____

Patient's Name: _____

Name of chaperone: _____ Method of transport_____

Chaperone mobile: _____

4. Pre-operative Assessment

AIRWAY

Are there any **AIRWAY** concerns?

(Mallampati score= 1-all/2-uvula/3-base/4-none. Head and neck movement. L.E.M.O.N assessment etc)

VITALS

Resting **BLOOD PRESSURE**?

(***RESTING*** BP MUST be <180/110 for sedation. Else refer to GP within 24h. >200/110 refer straight to A&E. ≥140/90 refer to GP for investigation. Leader, Ross, et al. "Hypertension– an update for the dental (sedation) team." Dental Update 46.6 (2019): 508-513.)

Resting SpO_2?

Resting HR?

Resting respiratory rate?

CHECKS

The written **CONSENT** has been completed and discussed verbally BEFORE the day of the treatment?

(Before day of treatment unless emergency procedure)

What is the **JUSTIFICATION** for sedation?

(Tx complexity + IOSN/MH/MDAS/anxiety/Gag reflex etc)

ASA?

(Guideline 1 or 2. 3 may be possible sometimes but further case review needed)

Check RMH/Sedation Hx/BMI appropriate?

(Guideline BMI >18 and <35. May still be possible but further case review needed)

Pre-operative assessment completed by? _____

Date completed? _____