



Informed Consent for Anaesthetics

As part of your treatment we are proposing to use a Local Anaesthetic.

This will involve a needle.

We offer 2 basic types of Local Anaesthetic

1. With Adrenaline
2. Without Adrenaline

It is essential that your Medical History is Up To Date.

The risks and side effects include

- | | |
|--|--------------|
| Fast heart beat | Fainting |
| Mild dizziness | Bruising, |
| Paresthesia (Tingling and/or numbness) Short term | Soreness |
| Paresthesia (Tingling and/or numbness) Permanent | Allergy |
| Risk of lip chewing | Swelling |
| Trismus | Lockjaw |
| Nausea | Hematoma |
| Temporary Facial Numbness (Facial Nerve) | Infection |
| Temporary problem with closing eye on same side (Facial Nerve) | Palpitations |

Patient must follow the post treatment instructions for the procedure

You will have some numbness and it is important not to chew your lip or scald your mouth with hot food or liquids if you do you will not feel it but when the anaesthetic wears off there can be a lot of damage.

I certify that I have read fully and understand the above authorization and informed consent.

PATIENT CONSENT: by my signature below, I expressly acknowledge that:

The dentist has explained the options and risks of the proposed treatment. I understand the risks of the procedure, including the risks that are specific to me, and the likely outcomes. The dentist has explained other relevant treatment options and their associated risks.

The dentist has explained the alternative options for anaesthesia (local, sedation, general) and problems specific to each choice, and the likely outcomes if complications occur.

I was able to ask questions and raise concerns with the dentist about my condition, the procedure and its risks, and my options. My questions and concerns have been discussed and answered to my complete satisfaction.

I understand that no guarantee has been made that the anaesthesia will work.

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE LISTED HEREIN

I realise that signing this does not oblige me to have all or any part of the treatment proposed, but is simply an acknowledgement of the fact that I am giving my informed consent if I decide to go ahead.

(CF Local Anesthetic)

Name _____

Date of Birth ____//____//____

Signature _____

Date ____//____//____