Special Smiles, Ltd

WHAT YOU SHOULD KNOW ABOUT PRE-SEDATION AND GENERAL ANESTHESIA

Please Read All Information Carefully Before Signing

We are required to provide you with information regarding the treatment or procedures we are considering. We are also required to obtain your permission for any specific dental treatment, pre-sedation, patient management techniques or anesthesia, which might be of concern to the patient. When you sign consent, this means you have received enough information to make an informed personal choice concerning the proposed dental treatment, patient management, pre-sedation, and anesthesia services that will be administered after considering the risks, benefits, and alternatives. When you sign consent, this also means the details have been explained to you fully and you understand and agree with the proposed treatment plan.

We strive to provide the highest quality of service available in an outpatient setting. In some cases, the needs of the individual may not be appropriate for treatment under general anesthesia in an outpatient facility. Some of the difficulties that can interfere with proper evaluation and treatment include extensive medical conditions or physical limitations, hyperactivity, resistive or spastic movements, aggressive or physical resistance to treatment such as kicking, screaming, and grabbing the IV tubing or sharp dental instruments. In these instances we will do our best to serve each client with respect to their limitations. If we are not able to treat you, we will assist you in locating a provider that best suits your needs.

Several patient management techniques are used by Special Smiles to protect our clients from injuring themselves due to uncontrollable movements or maladaptive behaviors. First, and foremost, we do our best to communicate with each patient to ensure we understand their needs and desires before we use any form of restraint. Other patient management techniques are:

1. **Safety Belts**: Uncontrollable movements are a common occurrence during the administration of anesthesia. To protect clients from accidental injury, most surgery centers require patients to be secured to the operating room table. Special Smiles uses velcro attachments placed around the wrist and waist to secure each patient. Each loosely placed restraint is removed following surgery.

2. **Mouth Props**: After the patient is asleep, a rubber or plastic device is placed in the mouth to prevent closing when the individual has difficulty maintaining an open mouth.

3. **Pre-Sedation:** We use sedative drugs to relax patients who do not respond to other management techniques or who are unable to cooperate for operating room procedures. Oral drugs may be ordered by the primary care physician in advance of the appointment, or we may give medication on site. Pre-sedation on site is only given under the supervision of a licensed Anesthesiologist, and the decision is based on medical necessity. If the patient has received pre-sedation in the past, please discuss this with the dentist and/or anesthesiologist before scheduling an appointment.

4. **General Anesthesia:** On the day of surgery, anesthetic drugs are given via inhalation (breathing gas using a mask), or intravenously (through a tube placed in the vein) by an anesthesiologist. A small bruise may appear after the tube is removed. Once the anesthetic is administered patients are assisted with breathing using a ventilator attached to a small tube placed in their nose or mouth. The anesthesiologist monitors the patient throughout the procedure, and gives fluids or pain medication if necessary. After surgery patients are monitored by a Registered Nurse in recovery until they are discharged.

Special Smiles, Ltd

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PRE-OPERATIVE PHYSICAL EXAMINATION FOR DENTAL CARE UNDER GENERAL ANESTHESIA

A Primary Care Physician must complete all sections and return to Special Smiles, Ltd and include any notes from office visit. This physical will expire 90 days from the date signed. Thank You.

PATIENT NAME: _____

Date of Birth: ____/____/____

DATE OF SURGERY ____/____/____**
*MAY BE SCHEDULED AT LATER DATE

CURRENT MEDICATIONS

(Please list all medications, including Over the Counter medications. Attach additional pages if necessary)

Medication	Dosage	For the Treatment of

Please list all allergies to food, medication or latex. Include patient and/or family history of anesthesia complications:

Please describe any hospitalizations or changes in medical history over the past year: ☐ YES ☐ NO

CURRENT HEALTH STATUS/MEDICAL TREATMENTS/ISSUES

Please specify all conditions that were an issue within the last 12 months.

☐ ASTHMA	☐ YES ☐ NO	☐ MUSCULAR DISEASE	☐ YES ☐ NO
☐ APNEA /DYSPHAGIA	☐ YES ☐ NO	☐ TB/COPD/PNEUMONIA	☐ YES ☐ NO
☐ ANTI-COAGULANTS	☐ YES ☐ NO	Date of last /infiltrate	____/____/____
☐ AIRWAY PROBLEMS	☐ YES ☐ NO	☐ SEIZURE DISORDER	☐ YES ☐ NO
☐ BLEEDING DISORDERS	☐ YES ☐ NO	Change in Seizure ☐ Frequency ☐ Pattern ☐ Medication	
☐ CANCER	☐ YES ☐ NO	☐Other:_____	
☐ DIABETES ☐ TYPE 1	☐ TYPE 2	Date of Last Seizure	____/____/____
☐ HEART DISEASE	☐ YES ☐ NO	Hospitalized after seizure?	☐ YES ☐ NO
☐ HEPATITIS	☐ YES ☐ NO	☐ PEG TUBE FED	☐ YES ☐ NO
☐ HYPERTENSION	☐ YES ☐ NO	☐ SCOLIOSIS/ DEGREE OF CURVATURE _____	
☐ KIDNEY DISEASE	☐ YES ☐ NO	☐ SEXUALLY ACTIVE	☐ YES ☐ NO
☐ LIVER DISEASE	☐ YES ☐ NO	☐ WEIGHT GAIN/LOSS	☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE PROVIDE A COMPLETE DESCRIPTION FOR EACH CONDITION.

PATIENT NAME _____ **D.O.B.**_____ **DATE:** _____/_____/_____

PLEASE PROVIDE A COMPLETE DESCRIPTION FOR EACH ABNORMAL/OMITTED CONDITION

GENERAL APPEARANCE	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
MENTAL STATUS	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
SKIN/HEENT:	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
HEENT:	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
LYMPH NODES	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
LUNGS	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
HEART	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
ABDOMEN	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
URINARY	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
EXTREMITIES	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
MUSCULO-SKELETAL	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED
NEUROLOGY	[ ] NORMAL	[ ] ABNORMAL	[ ] OMITTED

Temperature **B/P** **Pulse** **Resp.** **Height** **Weight**

I HEREBY CERTIFY THAT I HAVE EXAMINED THE NAMED PATIENT AND ATTEST THAT HE/SHE IS STABLE TO UNDERGO DENTAL SURGERY UNDER GENERAL ANESTHESIA. THIS PHYSICAL WILL EXPIRE 90 DAYS FROM THE DATE SIGNED.

_____ **Physicians Signature**

_____/_____/_____ **Date**

_____ **Physicians Name (please print)**

_____ **Telephone Number/Fax Number**