Informed Consent for Use of Child Protective Stabilization

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment: _____

Protective stabilization includes using a papoose board and Velcro straps or being restrained by a parent, guardian and/or dental staff member. Recommended type of protective stabilization:

Initial all applicable statements

Protective stabilization is being recommended because:

_____ The patient is not yet able to cooperate due to age or mental or physical impairment and treatment is needed to prevent or treat pain/infection.

_____ The safety of the patient, staff or guardian may be at risk without the use of stabilization.

_____ Sedated patients may require stabilization to help reduce untoward movement.

_____ Other: _____

The dentist discussed with me and I understand that:

_____ Patients who are unable to cooperate may need to be physical stabilized to complete dental treatment.

_____ Stabilization allows dental treatment to be done more safely and effectively. I understand how stabilization helps to protect the patient.

_____ A mouth prop (tooth pillow) may be used to prevent the patient from biting down. It is comfortable and protective for the patient.

_____ Although a local anesthetic is used, patients may still cry or be upset.

Possible complications that have been explained to me include:

_____ Stabilization creates a chance of injury, such as bruising or skin abrasion, choking, panic attacks and injuries to the person performing the restraining.

The dentist and I have discussed the benefits and risks of alternatives to protective stabilization. These alternatives include:

_____ *Not having any treatment or postponing treatment.* Risks for this alternative: Delaying treatment may cause harm; the dental disease may progress; further damage to teeth may occur; swelling and infection may occur. The specific type(s) of risk in this case are:

_____ *Treatment under sedation*. This alternative presents risks related to necessary medications and mechanical ventilation (breathing machine), if required.

Check the boxes below that apply to you:

Consent

☐ I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed protective stabilization.

☐ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to use protective stabilization.

☐ I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr._ to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

This agreement and consent should remain in force unless withdrawn in writing by the person who has signed on behalf of this minor patient.

_____ _____

Patient or Patient's Representative Date

_____ _____

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with _____ (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

_____ _____

Dentist Signature Date