TTH
FAMILY DENTISTRY

Surgery Cancellation

In order for us to properly schedule and accommodate all of our patients who need hospital care, we have implemented an Oral Surgery Cancellation policy. All of our patients will be held to a $250 cancellation fee for all hospital cases cancelled without a two-week notice and placed at the bottom of our surgery list.

We reserve the right to cancel surgery if we have not received a **completed** Health and Physical form (located in our OR Packet) in our office **one week** prior to your scheduled surgery date.

_____ _____

Patient Signature Date

_____ _____

Print Parent/Legal Guardian Date

_____ _____

Signature Parent/ Legal Guardian Date

WakeMed

Patient Name_____ **Date of Birth**_____

It is important for WakeMed to verify your medications upon arrival and again at discharge.

Allergies (Include medications, latex, X-Ray dyes, seafood, and other foods,etc.) ☐ **None**	**REACTION**

Current Medications(Include vitamins, supplements, herbs & over-the-counter) ☐ **None**	**Dose as taken**	**Frequency**	**Last Taken (Date/Time)**	**Reason per patient**

Please bring all medications you are now taking with you and the original containers.

Past Procedures and Major Surgeries : Please list all cardiac tests(stress test,echo,etc.) and procedures.	**Month/Year**	**Where**

Name of Pharmacy	**Phone #**

Name of Physicians	**Phone #**

This form is not a permanent part of the medical record.

February, 2009

CONSENT FOR SURGERY AND SPECIAL PROCEDURES Dental

I have explained to the patient those matters identified in paragraphs 1 through 9, below, including the information related to the administration of anesthesia described in paragraph 3, below, if anesthesia is not to be administered by American Anesthesiology of North Carolina. I have explained the potential need for the use of blood and/or blood components during this procedure and seven (7) days (including the date of the procedure) following the procedure end. Related risks, benefits and alternatives to blood or blood products have been discussed, if applicable. (If Blood Administration is not applicable, check box and initial Section 10 on back of this form.)

Other remarks, if any _____

Provider Signature: _____ _____ _____ _____
Physician or Other Authorized Practitioner Obtaining Consent *Role in Procedure* *Time* *Date*

Provider Signature: _____ _____ _____ _____
(If applicable) *Physician or Other Authorized Practitioner Obtaining Consent* *Role in Procedure* *Time* *Date*

Provider signature above must be a physician or other authorized practitioner permitted to perform the procedure.

❑ **Check if additional procedure forms with specific risks/benefits/alternatives are attached**

1. A physician, or other authorized practitioner has explained to me:
   a. my current medical condition;
   b. the proposed treatment/procedure, including the use of local/topical anesthesia and/or minimal/moderate sedation during the procedure/ treatment, if applicable.
   c. the potential benefits and drawbacks and the likelihood of success;
   d. alternative treatments for the medical condition and the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services;
   e. the possible and probable risks involved with the treatment/procedure including bleeding, infection and death;
   f. the possible and probable risks involved without the treatment/procedure;
   g. that implants may be used during my surgery and may include but are not limited to artificial or natural tissue and/or metal or plastic materials;
   h. the foreseeable recovery process; and
   i. the long-term effects associated with the treatment of the condition; and
   j. whether a resident or non-physician practitioner will be completing this procedure or essential parts of this procedure.

2. I Legal Guardian/Patient authorize Dr. Tasha Hinton, DDS *(Insert name and title of physician(s) or other authorized practitioner(s) performing the procedure as identified on the medical record.)* and/or his associate(s) and such assistants as may be selected by said physician(s), to perform on _____ *(Myself or Patient Legal Name)* the following operation or procedure(s): **(IDENTIFY SITE AND SIDE IF APPROPRIATE AND USE NO ABBREVIATIONS)**

Comprehensive exam, cleaning, fillings, extractions, alveoplast
(Operation(s) or procedure(s) to be performed)
gingivectomy, crowns, bridges, bone graft, pulp therapy + biop

3. Anesthesia by the physician or authorized practitioner performing my operation or procedure or an emergency medicine physician or authorized practitioner for procedures done in the emergency department (if applicable). It has been explained to me that I may require any of the following
   a. Topical (application or injection of local anesthetic)
   b. Local (application or injection of local anesthetic)
   c. Minimal Sedation (Anxiolysis): a drug induced state during which patients respond normally to verbal commands. Although cognitive (mental) function and coordination may be impaired, breathing, heart rate and blood pressure are unaffected.
   d. Moderate Sedation/Analgesia ("Conscious Sedation"): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile (touch) stimulation. No interventions are required to maintain a patent (open) airway, and spontaneous breathing is adequate. Normal heart rate and blood pressure are usually maintained.
   e. Deep Sedation/Analgesia: a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. (Restricted to credentialed Anesthesiologists, Emergency Physicians, Pediatric and Adult Critical Care Physicians as per WakeMed sedation policy.)

4. I understand and agree that my procedure may be photographed and/or videotaped. I understand that these materials will be used for education and research, but will not be used for advertising purposes. I understand that the physician or authorized practitioner and the hospital may dispose of the photographs/videotapes upon completion of education and/or research.

5. a. I understand and agree that medical residents, providers with supervised privileges, or other specialized care providers may perform this procedure and/or participate in essential elements of my procedure as allowed by medical staff rules and regulations and hospital policy.
   b. I understand and agree that a student or other observer, or an industry representative for technical advice related to equipment or devices, may be present during my procedure.

6. a. I authorize and direct Raleigh Pathology Laboratory Associates or such others as it may deem appropriate to examine all such tissues, organs, limbs, foreign objects, prosthetic devices, and other devices as shall be removed by operation or biopsy performed upon me.
   b. I do further authorize and direct said Pathologist(s) to photograph, retain for scientific purposes or dispose of such items:
   ❑ (If exceptions, list all) _____

7. I realize that during the course of the treatment/procedure to be performed, circumstances may arise or conditions may be discovered which necessitate an extension of the planned procedure or the performance of a different procedure. Therefore, I authorize the performance of such other procedures as the physician or authorized practitioner and any consultant(s), in the exercise of their professional judgment, decide are necessary.

8. I understand and agree that life support measures might be necessary in order to perform and to take care of me during the treatment/procedure. If I have any active do not resuscitate orders as a result of an advance directive or otherwise, I am in agreement with the following (check one):
   - ❑ a. That resuscitation measures are not to be performed.
   - ❑ b. That the order that specifies that resuscitation measures are not to be performed will be temporarily suspended during the surgery/ procedure. If anesthesia is involved, the suspension will remain in place until the patient is released from the care of the anesthesiologist.
   - ❑ c. Other (to be specified) _____

I agree to abide with the request in this Section 8:

_____ _____ _____
Physician/Authorized Practitioner Signature ***Time*** ***Date***

I agree to abide with the request in this Section 8:

_____ _____ _____
Anesthesiologist/Anesthesia Practitioner Signature *(If applicable)* ***Time*** ***Date***

9. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure.

10. **Blood Administration**
    - ❑ **If box is checked by physician/authorized practitioner, sections 10a, 10b and 10c are NOT applicable for the planned procedure. Physician/Authorized Practitioner Initials _____**

    a. Adult, Emancipated Minor Patients, and Minors permitted by law to consent: (includes unemancipated pregnant minors consenting to care for the prevention, diagnosis or treatment of pregnancy).
    It has been explained to me that blood or blood components may be administered when deemed a medical necessity, in an emergency, or life threatening situation. I authorize the administration of blood or blood components as is deemed necessary and desirable in the professional judgement of those persons listed above in statement 2.
    ❑ **accept** ❑ **decline (complete Section 10c.)**

    b. Unemancipated Minors and Minors not otherwise permitted by law to consent: (includes unemancipated pregnant minors consenting to care unrelated to the prevention, diagnosis or treatment of pregnancy).
    I understand that if the proposed procedure is to be performed on an unemancipated minor or a minor not otherwise permitted by law to consent to the procedure, the physician will discuss with me whether or not blood or blood components may be refused. I understand Section 10c will ONLY be completed if the physician listed above and the anesthesiologist (if applicable) are in agreement to abide by my refusal.

    c. I request that no blood or blood components be administered to _____ during the procedure(s) described in paragraph 2 and the associated recovery period. I understand that refusal of blood components may result in a negative outcome from the procedure, including my/the patient's preventable death.
    List exceptions: _____

I agree to abide with the request in this section 10c.

_____ _____ _____
Physician/Authorized Practitioner Signature ***Time*** ***Date***

I agree to abide with the request in this section 10c.

_____ _____ _____
Anesthesiologist/Anesthesia Practitioner Signature *(If applicable)* ***Time*** ***Date***

11. I UNDERSTAND THE ADMINISTRATION OF SEDATION MAY INVOLVE SIDE EFFECTS AND RISKS TO ME, INCLUDING DROWSINESS, DIZZINESS, ALTERED BALANCE, AND FORGETFULNESS.
FOR OUTPATIENTS: I UNDERSTAND THAT I SHOULD NOT DRIVE A CAR, OPERATE ANY MOVING EQUIPMENT OR POWER TOOLS, DRINK ALCOHOLIC BEVERAGES, OR MAKE ANY IMPORTANT DECISIONS FOR 24 HOURS FOLLOWING SEDATION. I UNDERSTAND I SHOULD MAKE PROVISIONS FOR HOME

12. I HAVE HAD SUFFICIENT OPPORTUNITY TO DISCUSS MY CONDITION AND THE PROCEDURE TO BE PERFORMED WITH MY PHYSICIAN(S)/ AUTHORIZED PRACTITIONER(S) AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I HAVE INFORMED THE PHYSICIAN/ AUTHORIZED PRACTITIONER ABOUT MY SIGNIFICANT MEDICAL CONDITIONS, INCLUDING WHETHER I MAY BE PREGNANT. I BELIEVE I HAVE ADEQUATE KNOWLEDGE UPON WHICH TO BASE AN INFORMED CONSENT TO THE PROPOSED TREATMENT/PROCEDURE. I UNDERSTAND THAT MANY PHYSICIANS ON THE WAKEMED MEDICAL STAFFS AND OTHER HEALTH CARE PROVIDERS AT WAKEMED ARE INDEPENDENT PRACTITIONERS/INDEPENDENT CONTRACTORS/ IN PRIVATE PRACTICE NOT EMPLOYED BY WAKEMED, AND THAT WAKEMED IS NOT LIABLE FOR THEIR ACTS OR OMISSIONS.

Signature of Patient	*Printed Name of Patient*	*Time*	*Date*
Signature of Legal Representative	*Printed Name of Legal Representative*	*Relationship to Patient*	*Time*	*Date*
Signature of Witness #1 *(Employee or volunteer of a health care entity excluding family member)*	*Printed Name of Witness #1*	*Time*	*Date*
Signature of Witness #2 *(Required for telephone consent or competent patient physically unable to sign*)*	*Printed Name of Witness #2*	*Time*	*Date*

*Document reason competent patient unable to sign: _____

Interpreter/Reader (if applicable) _____

Patient Label
placed here

WakeMed
Consent for Surgery and Special Procedures