Implant Perio Inc
Periodontics, Implants & Oral Medicine

CONSENT FOR GENERAL ANAESTHESIA

OR SEDATION

To be completed by all patients undergoing GA or sedation.

DOCTORS RECORD

PROCEDURE

Dental _____

Max Fac _____

Medical _____

PREMED

Date/Time _____

Meidazolam 7.5g _____

Emla Patch _____

Other _____

HISTORY

Child	Anxiety	Gag	< 3 years
Extensive	Extractions	Infective	
Inad.local	Normal hrs	After hrs	
Adult	Mental State		

DRUGS AND CONSUMABLES

Midazolam tabs	15 mg		7.5mg	
Emla patch	X1		X2	
Anes Ext Set	X1			
Jelco/Introcan	X1		X2	
Webcol/Micropore/Cotton				
Syringe	2cc	5cc	10cc	20cc
Butterfly needles	18g	22g		
Glycopyrolate	0.1mg/ml or 2mg/ml			
Lignocaine	2%			
Midazolam	5mg/5cc or 15mg/cc			
Propfol	1%			
Ketamine	mg			
Mepyramine Mal	mg			
Rapifen/Alfentaniel	mg			

Other

PERSON RESPONSIBLE FOR ACCOUNT: (MAIN MEMBER)

Surname _____ Title: Full Names: _____

Postal Address _____

Home Address _____

Home Tel/Fax _____

Work _____

Tel/Fax _____

ID Number _____

Employer _____ Occupation: _____

Medical Aid Name _____ Package: _____

Medical Aid Number _____

PATIENT DETAILS

Surname _____ Full Names: _____

Dependent Code on Medical Aid _____

ID/Date of Birth _____

Address _____

_____

Authorisation Number _____

Service Date _____

MEDICAL QUESTIONAIRE

Age _____ Weight _____ kg Male _____ Female _____

Are you allergic to any medication? _____

Do you suffer from: _____ Asthma _____ High blood pressure _____

Diabetes _____ Heart Problems _____ Cold or Flu _____

Porphyria _____ Chronic runny nose _____

have you had any food or drink today? _____ At what time? _____

Do you take any medication regularly? _____

Have you had any adverse/unpleasant reaction to anaesthesia? _____

Other comments: _____

_____

_____

CONSENT FORM

Anaesthetist _____ Date _____

Procedure _____ Codes _____

I, the undersigned, hereby state that I am legally competent to give consent for this procedure and am aware of the nature and scope of the risks of the procedure and sedation to be performed.

I give permission to the doctors concerned to take any blood tests as may deem necessary in the event of contamination of body fluids or blood to the health worker concerned.

I accept full responsibility for the account in the event that my medical aid should, for whatever reason, fail to settle the amount in full.

Name _____

Signature _____

Signature as above is Patient _____ Parent _____ Guardian _____

Witnessed _____