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PLACE LABEL HERE.  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

ORIGINAL: Medical Records      COPY: Patient

**ANXIOLYSIS/MILD SEDATION INFORMATION FOR DENTAL TREATMENT OF CHILDREN**

**PRE-OPERATIVE INFORMATION**

Because of your child's dental needs and inability to cooperate due to anxiety, it will be necessary to give your child oral sedative medication(s), in addition to local anesthetics and possible nitrous oxide inhalation sedation. The following medication(s) will be given to your child by the dental staff or by the parent under direct supervision of the staff (unless told otherwise):

\_\_\_\_\_.  
The medication administration time will be \_\_\_\_\_ min. prior to the planned procedure time. The "planned procedure time" is the same time indicated on your appointment slip. It is your responsibility to be present with the patient and prescription in the dental clinic waiting room \_\_\_\_\_ min. prior to the procedure time.

The medication(s) should not put your child to sleep, and he/she should awaken easily. As with any sedative drug, your child may experience an opposite effect and become excited or irritable. Additional sedation risks include allergic reactions, upset stomach, vomiting, breathing difficulties or arrest of breathing.

On the day of the procedure, in addition to the sedative, give your child only those medications he/she takes routinely, unless otherwise instructed. Other than a small amount of juice or water to take with the medications, do not give your child any food or drink within 6 hours of the dental treatment time. In addition to sedative drugs, immobilization with a Papoose Board and placement of a mouth prop device may be necessary to facilitate treatment and reduce the likelihood of inadvertent injury to your child or to the dental personnel.

**NOTE: Have the sedation prescription filled by your pharmacy at least a week before the dental appointment.** Some prescriptions must be ordered or can take several days to prepare. If there are any problems in filling the prescription, Dentistry must be notified within a week before the appointment. Failure to obtain the prescription before the appointment may result in tardiness or cancellation of the appointment with insufficient notice, either of which will count as a broken appointment. Two broken appointments will result in inactivation of your child's dental chart and you will be asked to seek dental care elsewhere.

**POST-OPERATIVE INFORMATION**

Because your child received sedation medication(s) for dental surgery, he/she should be watched closely for the next few hours. Please do the following:

1. It is best to keep your child awake for 2 hours after the dental appointment.
2. Watch your child closely and do not leave him/her unsupervised for the rest of the day. Your child may be disoriented and may stagger while walking for the next few hours.
3. Do not allow your child to sleep with the chin dropped down to chest. This could prevent adequate breathing.
4. Do not allow your child to sleep with any dental gauze in the mouth. This could lead to accidental aspiration and choking.
5. Your child's stomach may feel upset for the next few hours. If vomiting occurs, keep your child's throat clear by holding his/her head down or to the side.
6. Watch for biting of the lip, cheek or tongue, or picking at the face due to numbness from the local anesthetic.
7. Give your child only clear liquids and soft foods today after the dental treatment.
8. Your child should be able to return to a normal diet and to any day-care or school activities tomorrow.

If there are any complications (such as difficulty breathing or exceptional drowsiness) or if you have other questions, write them down and ask Dr. \_\_\_\_\_ about them. The dentist can be reached at:

Daytime (Monday - Friday, 8:00 AM to 4:30 PM): **800-251-3627**

Dental Clinic, 1222 JPA (434) 924-1774       University of Virginia Children's Hospital (434) 924-0847

After-Hours or on Weekends:

Call the Emergency Department at (434) 924-2231 and ask for the dental resident on call.

If you are unable to reach a dentist at these telephone numbers, you should seek emergency medical assistance.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient or Legal Authorization

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

Translation has been provided by: \_\_\_\_\_  
Signature of Health Care Provider/CyraCom ID#

\_\_\_\_\_  
Date

Recibí una copia traducida de este documento: \_\_\_\_\_  
(I received a translated copy of this document).      Iniciales del nombre del paciente (Patient initials)

Form #: \_\_\_\_\_