

### **INFORMATION SHEET FOR IV SEDATION/ GENERAL ANESTHESIA**

Dr. Callen has recommended dental treatment for your child to be performed during IV sedation/general anesthesia with Dr. Viola Devany. Dr. Devany is Board Certified in both Pediatrics and Anesthesiology. She will be providing anesthesia services for your child while dental cleaning, restorations or extractions are being performed by Dr. Marie Callen. This Service is provided in Dr. Callen's office.

In order to better care for your child and to maximize safety, Dr. Devany has arranged a protocol to follow:

1. You have received an information sheet, copies of consent form's, pre-op questionnaire and post-op instructions. Original consent forms to sign and date for both doctors will be given to you the day of the appointment.
2. Dr. Devany will call you the day before the scheduled time to discuss all the information you have provided, and review the plan, risks, and options with you. She will be glad to answer any questions you may have. She can also be reached at the numbers listed above.
3. Some children will be required to have their physician complete a routine history and physical form. Dr. Devany may call you a few days prior to the scheduled appointment and determine if this is necessary. If your child has a history of asthma, reactive airway disease, recurrent pneumonia or croup, or if your child is recovering from or has an active cold, please contact Dr. Devany 3-4 days before the appointment. Also, contact her early if your child has a strong history of snoring or large tonsils. If you anticipate that it will be difficult to contact you by phone, please contact Dr. Devany yourself. **No anesthetic services will be provided without a phone interview first.**
4. Patients will not be able to have any food after midnight the night before the procedure except for the following. Toast and jelly only is acceptable 6 hours before the scheduled procedure. He or she can have clear liquids (water, koolaide, Gatorade, apple juice, regular jello or regular popsicles) up to 4 hours before the appointment time. Clear liquids **do not include** milk, orange juice, gum, or candy.
5. Plan to arrive at the office 15 minutes before the appointment. Bring an extra set of clothes for the patient, in the event that there is an "accident."
6. **Bring another adult so one of you can sit beside your child on the way home.**
7. In order to set up the appointment, a deposit of \$630.00 will need to be left at Dr. Callen's office, made out to Viola Devany, M.D. This will cover the first hour of anesthesia time, drugs, and monitoring equipment. Additional time beyond this is provided at a fee schedule of \$65.00 every 15 minutes until the end of the procedure. The balance is due on the day of the service.
8. Have some clear liquids at home for the first "meal", (gingerale has anti-nausea qualities)
9. Dr. Devaney does not file for insurance re-imburement. **She will provide necessary information for those who wish to file with their own insurance companies.**
10. Please do not hesitate to ask questions. Our goal is to provide a safe and pleasant experience for you and your child.

## Pre-op Questionnaire

Patient's Name: \_\_\_\_\_ Male  Female

Patient's Age: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Weight: \_\_\_\_\_

<b>Is there a history of:</b>		<b>Y</b>	<b>N</b>
1.	Pre-Term- If yes, how many weeks? _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	Lung disease- asthma, croup, recurrent bronchitis, recurrent pneumonia. Explain: _____ When was last episode? _____ Medications: _____ Hospitalizations and /or ER visits: _____	<input type="checkbox"/>	<input type="checkbox"/>
3.	Sinus infections How often do they occur and when was the last one? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	Heart disease, heart murmur: _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	Seizures: _____ What medications? _____ How often are seizures and what type? _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	Musculoskeletal disease: _____	<input type="checkbox"/>	<input type="checkbox"/>
7.	<b>Current medications:</b> _____ _____ <b>Supplements:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
8.	<b>ALLERGIES</b> , including allergy to latex List allergies _____	<input type="checkbox"/>	<input type="checkbox"/>
9.	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
10.	Snoring: _____ Does it sounds like your child sometimes stops breathing? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

		<b>Y</b>	<b>N</b>
11.	Gastrointestinal problems- reflux, hepatitis, HIV? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
12.	Previous surgery or anesthesia: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
13.	Family history of anesthesia problems: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
14.	Family history of muscular dystrophy or other muscular diseases: _____	<input type="checkbox"/>	<input type="checkbox"/>
15.	Any other medical problems. Please list: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
16.	Smoker's in patient's life? _____  Smoke in the home? _____  Smoke outside home? _____	<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>	<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>
17.	Neurological developmental issues like autism, MRDD, CP? Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
18.	Phone numbers for pre- and post- contact by Dr. Devany: _____		

**Office notes only below this line**

---

**Patient's name:** \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_ Parent: \_\_\_\_\_

NPO: \_\_\_\_\_ Clear Liquids: \_\_\_\_\_

Rx#: \_\_\_\_\_ Prelone: \_\_\_\_\_

Other instructions: \_\_\_\_\_

PROQ# \_\_\_\_\_ 2 adults: \_\_\_\_\_

## Pre and Post-OP Instructions

### **What to do and what to expect on the day of your appointment:**

1. Your child may not have any food, milk, orange juice, gum or candy after midnight. He or she may have clear liquids up to 4 hours before the appointment. Toast and jelly only is acceptable 6 hours before the appointment.
2. Plan to arrive at the office 15 minutes before the appointment. This will allow time for any paper work to be finished.
3. For most children, the next step will be receiving the N<sub>2</sub>O (laughing gas) or “sleepy air”. Some toys are used to help distract from the start of the intravenous line (IV). Sedation is then started in intravenous line. Parents can stay with their child until the sedation is started. Your child will not remember anything after he/she starts staring.

Some small children and children with special needs will receive a quick shot in the arm which will produce a rapid drowsiness. Again, parents can stay until the sedation is started and the child will no longer remember them leaving.

4. While your child is sedated, he/she will be monitored with the same equipment as used in a hospital setting (EKG, blood pressure, respiratory status, oxygen level). In addition, oxygen will be given. The dentist will administer any local anesthetic that is necessary. Your child will take a “nap” while the dental work is being done.
5. At the end of the dental procedures, your child will wake up. He/she will still be drowsy for a few minutes. Most children wake up smoothly, but some children wake up fussy. You will be able to hold your child during this time. You will be discharged when your child can talk and stand up with help.
6. Discharge instructions include: Have your child in an age appropriate car restraint (car seat or seat belt). If your child falls asleep in the car, have the second adult tilt the chin up and not in a chin to chest position. This will keep the airway open.
7. After arriving home, your child can sleep but not in a bedroom where they cannot be seen. He or she should be in a room like the living room where you can watch him/her.
8. At home start with very mild and bland foods first, like clear liquids (Gatorade, 7up, apple juice) then soft food. Avoid dairy and plain water for a few hours. Later you can progress to a regular meal if your child tolerates the bland food first. If your child vomits, hold food and drinks for an hour then start again with clear liquids. If it happens again, call Dr. Devany.
9. Also contact Dr Devany if your child has a temperature of >100 F, or if there is swelling of the mouth or airway, or you have any other concerns. You may reach her on her cell phone at 937-974-4686 or home number at 937-552-7549.
10. For the remainder of the day, do not let your child do things that require coordination like riding a bike, rollerblading, climbing, swimming, etc.
11. Please ask any questions that you have, and tell us of any concerns that your child has. We want this to be a safe and pleasant experience for both you and your child.

# CONSENT FOR ANESTHESIA ADMINISTRATION

Date \_\_\_\_\_ Time \_\_\_\_\_

## CONSENT TO ADMINISTRATION

1. I hereby consent to the administration of anesthesia for (name) \_\_\_\_\_ by **Dr. Viola Devany** in conjunction with the dental procedure with **Dr. Marie Callen**. I consent to the administration of the anesthetic for my child (or the Child which I am legal guardian.)

2. I have been made aware of certain risks associated with this procedure. The risks include, but are not limited to: untoward reaction to anesthesia agents/drugs, nausea, vomiting, cardiac or respiratory arrest, aspiration, nerve damage, damage to the airway, brain damage, death or life threatening conditions. I acknowledge that no guarantees have been made to me concerning the results of having received anesthesia. Additional specific risks if applicable, \_\_\_\_\_

I have had sufficient opportunity to discuss this procedure, other options and all my questions have been answered. I believe that I have sufficient knowledge upon which I can base an informed consent to the administration of anesthesia.

\_\_\_\_\_  
date

\_\_\_\_\_  
parent, or guardian

**CONSENT FOR DENTAL TREATMENT WITH IN-OFFICE IV  
SEDATION / GENERAL ANESTHESIA**

I have been informed of and fully understand the dental procedure(s) necessary to treat my child. Even though I have been given an estimate, I understand that the treatment length and cost may vary once the treatment begins (treatment variations will be discussed with the parent/guardian as quickly as possible without interfering with treatment).

I consent to the administration of sedatives/general anesthetics for (name) \_\_\_\_\_ by a Dr. Viola Devany in conjunction with the dental procedure scheduled with Dr. Marie Callen. I acknowledge that Dr. Callen has explained to me that the sedatives/general anesthetics will be given to reduce the fear, anxiety or pain associated with the procedure and/or to limit physical activity so my child's dental treatment can be done.

The alternatives to the use of in-office sedation/general anesthesia drugs, as well as advantages and disadvantages of each alternative have also been explained to my satisfaction.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure and that these may include but are not limited to: adverse reaction to the sedative/anesthesia agents, nausea, vomiting, or atypical physiological response that may require hospitalization, further surgical procedures, disability, cardiac or respiratory arrest, aspiration, permanent or temporary nerve damage, damage to the airway, brain damage, life threatening conditions or death.

I acknowledge that all the questions I have asked concerning today's treatment have been answered to my satisfaction.

I am giving my full and informed consent to treatment to be rendered as described to me including any treatment based on new findings during the procedure.

Child's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_