

# Rice & Rollingson DENTISTRY

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## **Pre – operative IV Sedation**

1. Please do not eat solid foods for 6 hours prior to your appointment. If you need to take medication please do continue to take your medication.
2. Please do not drink anything for 3 hours prior to your appointment.
3. Please wear a short sleeved shirt.
4. Plan ahead.... If you are under 18 you must be accompanied by a responsible adult, who can sign for your sedation. Regardless of your age... you must have a ride home... you are considered impaired for 24 hours and cannot drive. You will also need someone to keep an eye on you following your appointment once you get home. Restart regular medications and take pain prescriptions as directed.

Dr. R.W. Rice and Dr. T. Rollingson  
335 Columbia Blvd. W  
Lethbridge, AB. T1K – 5Y8  
(403)381-7423

### **Following your IV sedation**

1. Medications are in you system for 18 hours. Do not drive, operate machinery or make important decisions for 18 – 24 hours. Your memory will be compromised during this recovery time. This is normal and temporary. Drink lots of fluids but refrain from alcohol for 24 hours.
2. You can eat right away. A meal however, may re-sedate you. You may feel somewhat re-sedated in any case, a few hours later. This is normal. Rest at home in the accompaniment of a responsible adult. Restart regular medications and take pain prescriptions as directed. Do not take any other non – prescribed medications without prior consultation.
3. Your face and tongue may still be numb. Avoid burns by consuming moderately warmed food and beverages. Parents; observe your children carefully for signs of lip, tongue or cheek biting.
4. We will call to see how you're feeling and answer your questions on the next business day, but if you or your family have any concerns in the meantime, call us at the office at (403)381-7423 or on Dr. Rollingson's cell (403)393-3436.
5. The IV site may be tender for a few days. Avoid heavy use of your IV arm for 48 hours. Contact our office if discomfort increases.
6. Do not drive or operate machinery for 24 hours.

## **POST – OP INSTRUCTIONS**

Swelling, discomfort, stiffness and a small amount of bleeding following oral surgery is normal and expected. By following these instructions all of these can be kept to a minimum.

1. **DO NOT** smoke for at least 48 hours after surgery.
2. **DO NOT** use a straw for 48 hours after surgery.
3. **DO NOT** drink hot liquids or eat hot foods for 24 hours after surgery.
4. **DO NOT** rinse your mouth or brush you teeth until the day after the surgery.
5. **DO NOT** touch the area where the work was done with your tongue or fingers.
6. For the first day or two, limit your diet to soft food, these may be warm or cold but not hot.
7. Starting the day after the surgery, start brushing and rinsing your mouth. Be gentle but thorough; cleanliness is essential to proper healing. To rinse, we recommend ½ teaspoon of salt in one cup of warm water, four times daily.
8. Should bleeding occur, apply firm pressure with the cotton bandage you have been given for approximately 15 mins and repeat as needed. Should bleeding be excessive or prolonged, call the office (403)381-7423
9. Take you medications only as prescribed. Should the medication be inadequate, call the office.
10. Place ice packs to the area for 20 mins and then remove for 20 mins, repeat for 4-5 hours.
11. If you have been sedated, you **MUST NOT** operate a motor vehicle, hazardous devices or machinery, including household appliances, for 24 hours or more, until fully recovered from the effects of the anesthetic or drugs given for your care.
12. The use of alcohol, tobacco, and certain other drugs after sedation may be life endangering and must me avoided.

If you have any questions consult with Dr. Rice/Dr. Rollingson or your family physician.

### **IN CASE OF EMERGENCY POST SURGERY CALL:**

Dr. RW Rice  
335 Columbia Blvd. W  
Lethbridge, AB T1K 5Y8  
(403)381-7423

Dr. Tim Rollingson  
335 Columbia Blvd. W  
Lethbridge, AB T1K 5Y8  
(403)381-7423 (403)393-3436 (cell)

*Robert W. Rice B.Sc. D.D.S.  
Tim Rollingson B.Sc. D.D.S.  
335 Columbia Blvd. West  
Lethbridge, Alberta T1K 5Y8  
Telephone (403)381-7423*

## **TREATMENT CONSENT FORM**

What you are being asked to sign is a confirmation that we have discussed the nature and the purpose of dental treatment, the known risks associated with the dental treatment, and the feasible treatment alternatives, and that you have been given an opportunity to ask questions and those questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand.

### **My signature on the bottom of this form certifies that:**

1. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.
2. I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.
3. I understand that the estimate given to me is for normal and usual treatment.
4. I understand that Dr. Rice/Dr. Rollingson have carefully examined my mouth. Alternatives to the chosen treatment have been explained. I have been informed and I understand the purpose and the nature of the dental procedure. I understand the procedures that are necessary to accomplish completion of the dental treatment and fabrication of the prostheses.
5. I have been informed of the possible risks and complications involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip, tongue, chin, cheek or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.
6. I have been informed of the possible risks and complications involved with dental treatment that include but are not limited to: root canal therapy, fracture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications may necessitate further treatment.

Patient/Guardian Initial\_\_\_\_\_

7. I understand that if nothing is done, any of the following could occur: loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need for extraction, fracture of teeth and/or roots , difficulties in chewing and/or speech. Also possible are temporomandibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.
8. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food insect bites, anesthetics, pollens, dust, any blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
9. Dr. Rice/Dr. Rollingson has explained that there is no method to accurately predict the gum and the bone healing capabilities on each patient following tooth extraction or surgery.
10. I also understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of surgery. I agree to follow the home care instructions provided to me. I agree to report to Dr. Rice/Dr. Rollingson for regular examinations as indicated.
11. I agree to the type of anesthesia, depending on the choice of the doctor. If I have been sedated, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more after surgery, until fully recovered from the effects of the anesthetic or drugs given in my care.
12. I request and authorize medical/dental service for myself. I fully understand that during, and following the contemplated procedure, surgery, treatment conditions may become apparent which warrant, in judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, material, or care, if it is felt this is for my best interest.

**FOR ALL PATIENTS**

I have been fully informed of the nature of dental treatment along with possible risks and complications and hereby consent to treatment.

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Date	Print Name	Signature of Patient/Guardian
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Date	Print Name	Signature of Doctor
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Date	Print Name	Signature of Witness
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