Greenwoods™
Dental & Surgical Centres
Dr. D.K Mittal Dental Corporation

Consent to Procedure, Treatment, or Investigation

I hereby authorize and request Dr. _____ , along with any assistant he/she feels necessary, to perform upon me the following operation(s):

_____

I understand that the nature and purpose of the above-mentioned procedure(s) is/are to:

_____

I also authorize Dr. _____ to do any therapeutic procedure or investigation that in his/her judgement may be advisable for my well-being.

The nature of the planned operation has been thoroughly explained to me and I have decided to proceed with this form of therapy over other alternate methods. I understand that that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made about the results of the operation or procedure planned. Furthermore, the risks and complications inherent in the operation have been explained to me and I accept these.

I further give permission to have such anaesthetics administered to as Dr. _____ or the anaesthetist deem necessary or advisable.

Pictures may be taken of the treatment site for record purposes, I understand that these photographs / videos will be the property of the attending physician. I do _____ / do not _____ agree to allow these pictures to be used for publication or teaching purposes. If I agree, I understand that my name and identity will be kept confidential and protected.

I agree to keep the office of Dr. _____ informed of my post-operative progress and I agree to cooperate with instructions given for my post-operative care.

In the event that a health care provider experiences a significant exposure to my body fluids, I consent to a sample of my blood being drawn and tested for transmissible infections (Hepatitis B, Hepatitis C, Human Immunodeficiency Virus), with the understanding that the results will be made known both to myself and to the exposed individual.

I have read the above form, and understanding its contents, I consent to this surgical procedure

Signature of Patient or Legal Guardian _____

Name (Please Print) _____

Relationship (If legal Guardian) _____

Witness: _____

Date: _____

I hereby acknowledge receiving a copy of the post-operative instructions which have been reviewed with me. I understand the advice and restrictions give and agree to abide by them. I will notify my doctor immediately if any unusual bleeding, respiratory problems, or acute pain occurs after my discharge from Greenwoods Dental Centre.

_____ _____

Signature of responsible party Date

_____

Witness

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Pediatric Pre-Operative Assessment

THIS PAGE IS TO BE COMPLETED BY PATIENT'S PARENTS/LEGAL GUARDIAN

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Planned Dental Treatment: _____

1. Has your child been seen or treated in a hospital? Yes / No

If yes, when?

_____

2. Any complications? Yes / No

If yes, please describe:

_____

3. Has your child ever had an anesthetic? Yes / No

4. Did your child have any problems with an anesthetic? Yes / No

If yes, please describe:

_____

5. Has anyone in your family had a problem with an anesthetic? Yes / No

If yes, when?

_____

6. Does your child have any allergies? Yes / No

If yes, please describe:

_____

7. Was an allergy due to:	**a) medicine**	Yes / No	if yes, please describe: _____
	b) food	Yes / No	if yes, please describe: _____
	c) other	Yes / No	if yes, please describe: _____

8. If your child has an allergy, do they have:	**a) rash or hives**	Yes / No
	b) trouble breathing	Yes / No
	b) high fever	Yes / No

9. **Has your child had a cold or cough in the past week?** Yes / No if yes, please describe: _____

10. has your child been exposed to any infectious diseases in the past month? (e.g. chicken pox, measles, etc) Yes / No

If yes, please list: _____

11. Does your child have:	**a) breathing problems**	Yes / No	if yes, please describe: _____
	b) heart problems	Yes / No	if yes, please describe: _____
	c) seizure disorder	Yes / No	if yes, please describe: _____
	d) developmental delay	Yes / No	if yes, please describe: _____
	c) diabetes	Yes / No	if yes, please describe: _____
	c) other	Yes / No	if yes, please describe: _____

12. Is your child receiving any medication now? Yes / No if yes, please list: _____

13. Does your child or anyone in the family have a bleeding problem? Yes / No

If yes, please list: _____

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Pediatric Pre-Operative Assessment

THIS FORM IS TO BE COMPLETED BY A PHYSICIAN

Name: _____ **Male:** ☐ **Female:** ☐ **Date:** _____

Date of birth: _____ **Email:** _____

Address: _____ **Home Phone:** _____

_____ **Postal Code:** _____ **Mobile Phone:** _____

Patient Demographics

D.O.B: _____ Ex-Prem : ☐ No ☐ Yes Gestrational Age at Birth: _____weeks Hospital _____

Summary of Past/Current Medical /Surgical Problems (severity and treatment)

Precaution Alerts: ☐ Methicillin resistant Staphylococcus Aureaus (MRSA +) ☐ Other _____

Review of Systems

Other (including Family History of Anesthetic Problems)

Medications:
(Including over the counter)
Current: _____
_____

Other Medications: _____
(in past year)
_____

Allergies
(Latex, Drugs, Foods, Other)
Type _____ Reaction _____
_____ _____
_____ _____

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Pediatric Pre-Operative Assessment

Physical Exam

Weight: _____ (kg) Height: _____ (cm) Temp: _____ HR: _____ BP: _____ SpO2: _____ RR: _____

	N	AbN	Explain if Abnormal
Airway / Neck			
CVS			
Respiratory			
Abdomen			
Neuro			
Spine			
Musculoskeletal			
Skin			

GUIDELINES FOR PRE-OPERATIVE TESTING IN CHILDREN

A. Hemoglobin

1. Infants < 1 year
2. Patients at risk for hemoglobinopathy (i.e. affro caribbeans, (i.e. affro caribbeans, hemophiliacs, positve family history)
3. Patients with history of chronic disease (e.g. congenital heart, rheumatoid arthritis, cystic fibrosia, chronic renal failure, mallgnancy, chemotherapy)
4. Surgery associated with potential significant blood loss
   - tonsillectomy and adenoidectomy
   - cleft palate
   - craniofacial repair
   - burn grafting
   - major orthopedic procedures: scoliosis repair, osteotomy
   - liver biopsy
   - cardiac procedures
5. History and physical exam suggestive of anemia
   - chronic blood loss
   - dietary insufficiencie (e.g significant dental)
   - pregnancy
   - fatigue, pallor and tachycardia

A hemoglobin done within 3 months of the time of surgery is adequate, provided there has been no intercurrent change in medical status.

B. Sickle Cell Prep

All patients of Afro-Carribbean descent

C. Other Tests

The need for pre-operative urinalysis, electrolyte determinations and chest x-rays is guided by the history and physical exam

Current/Labwork/Consults/Investigations

IIb: _____ Sickle Cell: _____

Assessment/Perioperative Recommendations

Date: _____ Physician: _____ _____
(Printed Name) (Signature)

Contact Phone: _____

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Pediatric General Anesthesia Pre-Operative Instruction

Please Remember: It is important for your child's safety that you follow these instructions carefully

(Surgery may be cancelled if these instructions are not followed)

Arriving at the Appointment

- We request you are at least 30 mins prior to your scheduled appointment time. A parent or guardian should accompany the child and must remain in the clinic until the treatment is complete

Medications

- Some medicines should be taken ad others should no. It is important to discuss this with your dentist during the consultation appointment prior to surgery. Patients should take their usual medications with a sip of water on the morning of their surgery.

Food and Beverages

- It is EXTREMELY important that your child have an empty stomach when given an anesthetic. It will reduce the danger of vomiting and inhaling stomach contents into lungs while your child is asleep. You must follow these instructions or child's procedure will be cancelled to ensure his/her safety. We request no solid foods or unclear fluids (orange juice, milk, etc) are ingested after midnight the night prior to the appointment. This fasting is for your child's safety. A staff member will contacting you no later then 48 hours prior to the appointment to go over these instructions as well as to confirm the appointment. If we cannot confirm the appointment prior to the appointment, we will cancel the appointment and need to reschedule for a later date.

Personal

- We recommend your child come in comfortable, loose fitted clothing (pajamas, track/sweatpants and a t-shirt). If you are bringing a young child, please do not dress them in a "onesies" or "footy" pajamas. We also recommend older clothing, as they may get stained or dirty during procedure and recovery with blood or fluids. We often recommend a second set of clothing because it is possible they might have an accident. If you child wears diapers or pull-ups make sure they are fresh and bring a back up pair the day of surgery.

Change in Health Status

- If there are any changes in the child's health, such as a chest cold or fever the day of treatment, please contact our office immediately.

Activities

DO NOT plan activities for the child after treatment. Your child will likely want to rest upon returning home. Do not send your child to school or plan for activities. Please monitor your child throughout the day following surgery.

It is important that you understand the circumstances surrounding this treatment.

If you have any questions, please do not hesitate to ask them, please call our office 204-779-7779.

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Pediatric General Anesthesia Post-Operative Instruction

Please Remember: It is important for your child's safety that you follow these instructions carefully

Discharge

- We prefer that 2 adults accompany the child home in case the child needs assistance during the transport. Ensure that a responsible adult accompanying the child is able to drive or hire a taxi cab. Public transportation is not acceptable. We also recommend bringing a plastic bag for the ride home in case of any nausea or vomiting following surgery.

Food and Beverages

- To assist you child in a speedy recovery, it is important for your child to be well-hydrated after treatment. The first drink should be plain water then clear sweet drinks can be given. Things like clear juices, Gatorade, etc. Warm soft food may be taken when desired and in small portions such as Jell-o, pudding ,soup, mashed potatoes or ice cream. Do not encourage eating too soon because your child's stomach may be upset. If your child sleeps for a few hours wake him or her up to give liquids. Nausea and vomiting are not uncommon after surgery. Gravol suppositories work very well for postoperative vomiting. If vomiting persists, contact the dentist or anesthesiologist.

Numbness of the Mouth; Persistent Cough:

- Your child's cheeks, lips and tongue may be numb after treatment. Please watch your child carefully for several hours to make sure she/he does not bite the cheeks, lips or tongue. The anesthetic gas used is very dry and sometimes irritating. This may cause hoarseness or a croupy cough. Either of these conditions should pass within the first day.

Pain Management Afterwards

- Children's Acetaminophen (e.g Tylenol) or Ibuprofen (e.g. Advil or Motrin) every 6-8 hours will help alleviate discomfort and sore gums. Occasional post-operative fever may be managed with Acetaminophen also.

Dental Care After Treatment

- If you child received any stainless steel crowns his/her gums will be especially sore, because they fit below the gums. These crowns will fall out with the baby tooth when the permanent/adult tooth comes in. We recommend avoiding sticky foods until the crown has come out. If your child has had crowns or space maintainers placed, please do not allow toffee, gum, liquorice or ice chewing to prevent displacing or distorting them. If your child received a permanent stainless steel crown, please discuss care options with the dentist. If your child had teeth removed, it is important to avoid spitting or using a straw for at least 24 hours. Any bleeding can be controlled by biting (not chewing) firmly on gauze pads placed over the surgery site for at least twenty minutes. You doctor may recommend an appointment for apostoperative visit within two to four weeks.

Contact Us:

- If your child experiences the following for more than 24 hours following their appointment, please all the dentist:
  - Elevated fever
  - Severe bleeding of the gums
  - Severe pain
  - Severe vomiting or dizziness
- If your child has any of these symptoms during the evening or when the office is closed, please go to your nearest emergency room.

It is important that you understand the circumstances surrounding this treatment.

If you have any questions, please do not hesitate to ask them, please call our office 204-779-7779.