

Dr Vivian Mascarenhas, Dental Sedationist
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Perth Dental Sedation

Taking Anxiety Out Of Dentistry

Sedation dentistry reduces anxiety so you
can face dental appointments without fear



MEDICAL HISTORY, IMPORTANT INFORMATION, INSTRUCTIONS BEFORE & AFTER IV SEDATION & CONSENT FOR INTRAVENOUS SEDATION

Must be read, signed and returned 2 weeks prior to surgery

Patient information

Your Sedation and Sedationist:

- ❖ Your sedationist is with you throughout and immediately after your procedure and is responsible for your well-being. Your sedationist also takes an active role in conjunction with your surgeon in your pain management after the operation.
- ❖ To ensure your safety, intravenous sedation in the dental practice setting should only be administered by a suitably qualified medical or dental practitioner as laid out by the requirements of the Australian Health Professionals Regulation Agency (AHPRA) and the Australian and New Zealand College of Anaesthetists (ANZCA).
- ❖ **Dr Vivian Mascarenhas** B.D. Sc (UWA), BSc (UWA), PGrad Dip Clin Dent (Sedation and Pain Control) (Uni of Syd), has registered qualifications in Dental IV Sedation from Sydney University and is board endorsed for sedation with **AHPRA**.
- ❖ A full and through **pre-sedation medical history** is essential for your sedationist to find out about any potential complicating factors, request further medical information and investigations from your GP/Specialist (if required) and plan the most suitable sedation for your particular situation.
- ❖ Please take the time to accurately complete the attached **Medical History Form** and **return** to Dr Mascarenhas **at least 2 weeks** prior to your procedure.
- ❖ Prior to your sedation appointment Dr Mascarenhas will contact you to discuss your medical history and the sedation process. Generally, this can be done by phone a couple of days before your procedure. However, some patients may require an appointment at the surgery if their medical requirements are complex. Please feel free to discuss any questions or concerns with Dr Mascarenhas directly on 0407181911.
- ❖ As your safety and well-being is our primary concern, on rare occasions your sedationist may decide not to proceed, or shorten your sedation time due to any medical contraindications or failure to adhere to instructions prior to sedation.

- ❖ The duration of dental treatment can be difficult to predict and as a result, all of the required treatment may not be completed in the estimated time and as a result of this the sedation time may have to be extended on the day or a further appointment may be required, in which both would incur an additional fee.

Risks and Complications

- ❖ As with any anaesthetic procedure, IV Sedation is not without risk and there is an extremely remote risk of serious medical complications. These risks however are substantially less than for a general anaesthetic. Our service is specially equipped and qualified for administering IV Sedation; and for managing sedated patients and medical emergencies.
- ❖ Where medications are placed in the vein, there may be bruising, swelling or inflammation (phlebitis), which may cause discomfort and temporarily restrict arm and hand motion. Nausea and vomiting can occasionally take place.
- ❖ Other common, but temporary minor after/ side effects and complications include drowsiness, transient amnesia, shivering, nausea and vomiting, dry sore throat and drowsiness.

Pre-Sedation Instructions

- ❖ You **must fast for 6 hours** before sedation to ensure an empty stomach. This means **strictly no food or drink** (including water, lozenges or gum) is to be taken for 6 hours before the sedation. **TO DO OTHERWISE MAY BE LIFE THREATENING.** Patients with afternoon appointments may have 200mls of **water only**, 3 hours before their appointment.
- ❖ If you take **any medications** please discuss them with Dr Mascarenhas prior to treatment. Usually, any regular medications are to be taken as **normal** with only **a small sip of water** on the morning of sedation, whereas some medications will need to be altered or skipped procedure (e.g., blood thinners, diabetic medications; you will be advised if required to do so) depending on the medical condition and the medication.
- ❖ As a precaution, please ensure to **bring all prescribed medications** with you on the day of your sedation appointment.
- ❖ **Do not** drink alcohol, smoke or use any recreational drugs for at least 48 hours before and after the sedation.
- ❖ If you have a cold, flu or respiratory infection, you must tell us as soon as possible as you may need to be re-appointed to another day.
- ❖ Please wear warm comfortable, loose fitting clothing to allow access to your arms and torso for an IV line and for monitoring of your heart (ECG) & blood pressure. Please wear comfortable enclosed footwear (avoid flip-flops). Remove any jewellery, makeup, nail polish (on one finger) and contact lenses. Please bring a small blanket for your use (even if the weather is warm).

Initials and sign: _____

- ❖ You must advise Dr Mascarenhas of any changes to your medical history, including any new pills or medications, colds/ flu's or any allergies prior to the procedure.
- ❖ Please arrange a **responsible adult** to **escort** you to the surgery on the day of sedation and be available after the surgery for post-operative instructions, and to escort you home where they will be required to look after you for the **next 12 hours**.
- ❖ You **cannot** go home by Uber, Taxi or public transport or by walking, and you cannot go home without someone who is responsible for your care for the remainder of the day.
- ❖ If you are responsible for caring for others (children, elderly or disabled) please arrange for a responsible adult to assume responsibility and care for 24 hours.
- ❖ If you are breastfeeding, please call Dr Mascarenhas asap to discuss your instructions to minimise any disruptions to your baby.

Post-Sedation Instructions

- ❖ After the treatment, you must be escorted home by a **responsible adult** who will spend the next 12 hours with you at home and must be taken home in a private transport (Not taxis or public transport). Your procedure will be cancelled if you do not have a carer and transport arranged.
- ❖ You **must not** drive; operate machinery or potentially harmful equipment (including kitchen utensils) for 24 hours. Please rest reclined in your family room (not in bed) and be careful when standing quickly and walking.
- ❖ As you will have consented to the procedure and the treatment plan prior to the sedation, your payment will be processed immediately after your procedure, at/during recovery. Apart from the paperwork associated with your (prior approved) payment, we recommend that you do not sign any important documents until the next day.

Fees, Payments and Cancellations

The fees for sedation are dependent on your treatment time **plus** your recovery time (generally 15-30 min). As the sedation fees include post-operative monitoring and recovery, please account for 30 minutes more than your actual treatment time when planning your finances. Some patients may require additional drugs and/or recovery time and the fees charged may reflect this. Please see the last page for a full fee breakdown.

A non-refundable deposit may be required to book your sedation and treatment time, depending on the duration of the appointment. Sedation bookings are often lengthy and are exclusively set aside for you. For this reason, if you miss your appointment or cancel without a minimum of 48 hours' notice, you will incur a cancellation fee of \$150 per 1/2 hour of booking time.

All credit card and Eftpos transactions incur a 2% fee as charged by our merchants.

Please note: All anaesthetic medications are included in the fees.

Initials and sign: _____

Should your surgeon request additional medications during your surgery to improve your wellbeing and surgical outcome (such as IV antibiotics, corticosteroids Etc), these are charged at \$15 per medication. In rare circumstances emergency drugs may be used and are charged at higher varied rates.

CONSENT TO INTRAVENOUS SEDATION

If you have any questions or concerns about any of the above information, please call us prior to your appointment.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE DOCUMENT:

“IMPORTANT INFORMATION, INSTRUCTIONS & CONSENT FOR INTRAVENOUS SEDATION, BEFORE & AFTER IV SEDATION, FEE SCHEDULE AND BREAKDOWN” Pages 1 to 8

AND CONSENT TO INTRAVENOUS SEDATION FOR MY PROCEDURE(S). THIS CONSENT EXTENDS TO ALL SUBSEQUENT APPOINTMENTS FOR WHICH I REQUEST INTRAVENOUS SEDATION.

Patient Name: _____

Patient (or Legal Guardian) Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Initials and sign: _____

MEDICAL HISTORY QUESTIONNAIRE

DATE: _____ DATE OF PROCEDURE _____

Name (Last, First, M.I.):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Age: DOB:
Address:		Suburb:	Postcode:
Phone (Mobile):	Phone (Hm):	Phone (Work):	
Email:	Your Dental Practice:		

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE HIGHLY RELEVANT FOR YOUR SAFETY AND WILL BE KEPT STRICTLY CONFIDENTIAL. PLEASE COMPLETE THEM ALL.

Name & location of your Medical Doctor (GP) or Specialist in charge of your care:

Next of Kin: Name: _____ Address: _____ Mob: _____

Please list any current medical investigations you are having. Please specify:

MEDICAL HISTORY

Please TICK if you have, or have ever had, any symptoms in the following areas and briefly explain:					
<input type="checkbox"/>	Heart trouble/ Heart Attack/ Angina	<input type="checkbox"/>	Shortness of Breath/chest trouble	<input type="checkbox"/>	Reflux or indigestion
<input type="checkbox"/>	Heart Murmur/ Prosthetic Valve	<input type="checkbox"/>	Any Lung Condition	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Asthma/ Bronchitis	<input type="checkbox"/>	Artificial Joints
<input type="checkbox"/>	Congenital Heart Disease	<input type="checkbox"/>	Emphysema or lung condition	<input type="checkbox"/>	Osteoporosis or Any Bone Disease
<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/> Obstructive Sleep Apnea (OSA) <input type="checkbox"/> Snore	<input type="checkbox"/>	Bisphosphonates medications or infusions
<input type="checkbox"/>	High or Low Blood Pressure	<input type="checkbox"/>	Liver problems or Jaundice	<input type="checkbox"/>	Epilepsy, seizures or faints
<input type="checkbox"/>	Blood Thinners (Anti-coagulants)	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Depression or Anxiety
<input type="checkbox"/>	Bleeding Disorders, Excessive Bruising/ Bleeding or Anemias	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Mental or Psychiatric conditions
<input type="checkbox"/>	Stroke, TIA or DVT	<input type="checkbox"/>	Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II Do You Take Insulin <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Mandatory: Your Height: _____ cms Your Weight: _____ Kgs
<input type="checkbox"/>	Females Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If So, Due Date? _____ Are You Breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Cancer, Chemotherapy or Radiotherapy Please Specify:	<input type="checkbox"/>	Other Medical Conditions - Please specify:

Please List **ALL MEDICATIONS** you are taking (including non-prescribed herbal and over the counter medications):

Initials and sign: _____

Do you have ANY ALLERGIES? Including Drugs (i.e., Penicillin), foods (i.e., Eggs), or Substances (i.e., Iodine)		
Have you had any previous Operations/Anaesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No – If yes please specify type and how long ago:		
Have you or a family member ever had any complications with Operations or Anaesthetics? <input type="checkbox"/> Yes <input type="checkbox"/> No – If yes please specify		
Have you taken any steroid medication in the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No – If yes please specify		
Have you ever had Neck or spinal damage? (e.g., back and neck injuries or limitation of movement) <input type="checkbox"/> Yes <input type="checkbox"/> No – If yes please specify		

HEALTH HABITS AND PERSONAL SAFETY

Exercise	How often do you exercise in a week?		
	How many flights of stairs (each is 10 steps) can you climb before getting short of breath? _____		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, How many standard drinks per day?	How many drinks per week?	
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you, or have you used any recreational drugs e.g. Marijuana or IV drugs		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes please specify type:	Last used:	
Personal Safety	Do you care for others e.g., Children, Elderly, or Disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Why do you want IV Sedation for your dental procedure?

<input type="checkbox"/> High Anxiety	<input type="checkbox"/> Hypersensitive Gag Reflex	<input type="checkbox"/> Pain	<input type="checkbox"/> Noise of Drill	<input type="checkbox"/> Smell of Dentist
<input type="checkbox"/> Previous Bad Experience	<input type="checkbox"/> Complex Procedure	<input type="checkbox"/> Require a lot of work	<input type="checkbox"/> Needle Phobia	<input type="checkbox"/> Other _____

Declaration:

In signing this form, I acknowledge that this represents an accurate medical history. I will advise my sedationist of any changes to my medical history in the future. I understand that all medical details will be treated with complete professional confidentiality.

Patient Signature..... Date.....
 (Parent or guardian if under 18 years old)

[Office use only]

Date reviewed: _____ Medical summary required: Yes No / Investigations required: Yes No /
 Pre/post-op insts given: Yes No / Consent received: Yes No
 Patient Telephone Summary: _____

Initials and sign: _____

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For Bookings

Please liaise directly with your dental clinic or

Call **Dr Vivian Mascarenhas** on
0407181911

Sedation Fees and Item Number Guide

- This fee schedule is effective as of September 2021
- A non-refundable **\$200 deposit** is required when booking
- There is a **2% CC fee** for all cards and Eftpos payments
- **Please note:** Should your surgeon request additional medications (such as IV antibiotics, corticosteroids Etc) during your surgery to improve your wellbeing and outcome, these are charged at \$15 per medication. All anaesthetic medications are included in the fees.

Dental Item Numbers: You **may** qualify for **some** Health Fund Rebates (Not Medicare) depending on your fund and level of cover. - Please check with your respective funds to confirm your rebate. (Generally, rebates range between \$100 to \$450 but this is entirely dependent on the plan (contract) between the patient and their health fund and the sedation time). The following are the correct Dental item numbers used for dental IV sedation:

- 015 - Consultation Extended
- 916 – Travel to provide services
- 942 – Sedation Intravenous – (per 30 min or part thereof)
- 928 – IV cannulation
- 927 – Provision of medication

Please note: There is no Medicare rebate available.

Duration of Sedation and Recovery	Total Fee
1 Hour (Minimum)	\$ 880
30min	\$ 1100
2 Hour	\$ 1350
30 min	\$ 1600
3 Hour	\$ 1900
30 min	\$ 2200
4 Hour	\$ 2500
Please Call for fees for extended times	

There are **Unique and Specific Patient**

Instructions regarding Dental IV Sedation

please obtain the following (complete and return prior to your planned sedation):

- **Sedation Medical History Form**
- **Pre & Post Sedation Instructions & IV Sedation Consent form**

either from your dental practice or on the website:

<http://www.perthdentalsedation.com/for-patients.html>

Please see the next page for the item number and fee breakdown

Initials and sign: _____

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Sedation Item Number and Fee Breakdown

<p>Due to increased complexity, over 4 hours sedations are priced individually based on the individual patient requirements and medical histories. Please call to discuss</p>	<p>1 Hour (Minimum) \$880 Item Code Fee 015 - \$150 916 - \$50 928 - \$70 942 - \$180 (per30 min) x2 (\$360) 927 - \$250</p>
<p>1 Hour and 30 min \$1100 Item Code Fee 015 - \$150 916 - \$50 928 - \$70 942 - \$180 (per30 min) x3 (\$540) 927 - \$290</p>	<p>2 Hours \$1350 Item Code Fee 015 - \$150 916 - \$50 928 - \$70 942 - \$180 (per30 min) x4 (\$720) 927 - \$360</p>
<p>2 Hours and 30 min \$1600 Item Code Fee 015 - \$150 916 - \$50 928 - \$70 942 - \$180(per30 min) x5 (\$900) 927 - \$430</p>	<p>3 Hours \$1900 Item Code Fee 015 - \$150 916 - \$50 928 - \$70 942 - \$180 (per30 min) x6 (\$1080) 927 - \$550</p>
<p>3 Hours and 30 min \$2200 Item Code Fee 015 - \$150 916 - \$50 928 - \$70 942 - \$180 (per30 min) x7 (\$1260) 927 - \$670</p>	<p>4 Hours \$2500 Item Code Fee 015 - \$150 916 - \$50 928 - \$70 942 - \$180 (per30 min) x8 (\$1440) 927 - \$790</p>

Initials and sign: _____