Consent for Protective Stabilization

1. ___________________________ have discussed the use of protective stabilization with my dentist and agree to the use of stabilization in order to complete needed dental care for my child, ___________________________.

After discussion with the dentist, I agree to the use of the following protective stabilization procedure:

Protective Stabilization: This is a device for limiting the disruptive child's movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in the device and placed in a reclined dental chair. I understand I have the right to be with the patient during this procedure.

I understand that the reason my child needs stabilization is the following: (check one):

___ 1. He/she requires immediate diagnosis and/or limited treatment and cannot cooperate, due to a lack of maturity.

___ 2. He/she requires immediate diagnosis and/or limited treatment and cannot cooperate, due to mental or physical disability.

___ 3. Either, my child and/or the dentist and staff would be at risk without the protective use of stabilization.

I understand that the benefits of this procedure are the following:

1. Reduction or elimination of untimely movement.
2. Protection of the child and dental staff from injury.

I understand that the use of protective stabilization should not occur with patients:

1. Who cannot be immobilized safely due to associated medical or physical conditions.
2. Who have experienced previous physical or psychological trauma from protective stabilization (unless no other alternatives are available).
3. Cooperative nonsedated patients.
4. Nonsedated patients with nonemergent treatment requiring lengthy appointments.

Note: Stabilization and any treatment will be terminated whenever a patient is experiencing severe stress or hysteric to prevent possible physical or psychological trauma.

I understand that the use of protective stabilization has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, violation of a patient's rights, and even death. I understand that the alternative management procedures are sedation and general anesthesia.

Parent/Guardian Signature ___________________________ Date ________________ Witness Signature ___________________________ Date ________________

Doctor Signature ___________________________ Date ________________

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