

small smiles

DENTISTRY OF SYRACUSE

SERVING MEDICAID CHILDREN

224 SOUTH GEDDES ST.

SYRACUSE, NY 13204

PH 315-471-0550 FAX 315-471-0770

Consent for Protective Stabilization

I, _____, 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.
- 3. Facilitation of the delivery of quality dental treatment.

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 hysterics 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

