Saskatchewan Health Authority

CONSENT FOR DENTAL TREATMENT

LONG TERM CARE
ORAL HEALTH PROGRAM
HOME: _____

Re:

Resident's name: _____

I, the person signed below, give consent for the following dental treatment, procedure or surgical operation to be provided by an oral health professional (dentist, dental assistant, dental hygienist, dental therapist and denturist as required):

The treatment is:

_____

_____

The nature, possible effects, risks and alternatives to this treatment have been explained to me. I understand the explanation and the alternatives. A prescription for mild oral sedation may be required prior to dental treatment. If necessary, I consent to the physician providing a sedation prescription.

I consent to receiving anesthetic, and to the use of anesthetics as may be considered necessary. I consent that the oral health providers may provide additional treatment if it is considered immediately necessary. I also consent that the oral care providers may be assisted by other oral/health care providers and that they may perform all or part of the treatment.

The collection of health and dental information is consistent with the requirements of our profession and those of *The Health Information Protection Act of Saskatchewan* and the *Personal Information Protection and Electronic Documents Act of Canada*. We acknowledge our duty and responsibility to hold in confidence your personal health information gathered in the course of our professional relationship.

I understand it is my responsibility to pay for dental treatment.

I understand if I have provided an email address that correspondence may occur through email.

Signed: _____ Date: _____
(Resident or Responsible Party)

Print Name: _____

Complete and sign the *Consent for Dental Treatment* and return to:

_____

_____

_____