NITROUS OXIDE CONSENT FOR MINORS

Please call our office at 920.729.7105 if you have any questions.

I, _____

parent/legal guardian of _____,

DOB, _____, authorize:

_____

to use nitrous oxide for the purpose of pain and anxiety control during my procedure. I certify that I have read this form or have had it read to me and my questions have been adequately answered and that I fully understand its contents.

The risks and benefits of inhaled nitrous oxide for pain and anxiety control have been explained to me as have alternative forms of pain control options.

I understand that using nitrous oxide may make me unsteady and that if I need to get out of the bed or off the procedure table, I will do so only with assistance.

I agree to hold the mouthpiece/mask without assistance from others.

I understand that some possible side effects of nitrous oxide include dizziness, nausea, light-headedness and unsteadiness.

I understand that nitrous oxide has been safely used throughout the world for pain and anxiety management for many decades and continues to be used worldwide today. I also understand that the risks for nitrous oxide use are the same risks that exist for virtually all other pain-relieving medications that I may choose to use during my procedure.

By signing this form, I agree to be treated by my doctor, and others following my doctor's orders. I understand there is a fee for nitrous oxide administration and that the fee will be paid at the time of service, and that this is not billed to my insurance on behalf of Women's Care of Wisconsin.

I understand, agree to the above, and wish to use nitrous oxide during my procedure.

CONTRAINDICATIONS

Please let us know if you have any of the following medical conditions, as we may not be able to safely use nitrous oxide:

- ☐ YES Recent ophthalmic procedure or surgery
- ☐ YES Severe congestive heart failure
- ☐ YES Severe coronary artery disease
- ☐ YES Severe COPD
- ☐ YES Air embolism
- ☐ YES Pneumothorax
- ☐ YES Recent pneumoencephalogram
- ☐ YES Intracranial air
- ☐ YES Lung cysts
- ☐ YES Active sinus or middle ear problems
- ☐ YES Pulmonary HTN
- ☐ YES Bowel obstruction
- ☐ YES Chemotherapy with Bleomycin at any time in the past
- ☐ YES Sickle cell anemia
- ☐ YES Pregnancy in the first trimester
- ☐ YES Decompression sickness
- ☐ YES Head injury or intracranial mass lesions
- ☐ YES Anemia of unclear etiology
- ☐ YES Elevated MCV on routine CBC
- ☐ YES Post gastrectomy
- ☐ YES Known or suspected B12 deficiency, untreated

Please tell us if you have eaten in the past two hours.
Please tell us if you have used any recreational drugs in the past week.

_____

Patient / Legal Guardian Date

_____

Relationship to Patient

_____

Witness Date