

SAMPLE INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE

Authorization for Dental Treatment

I hereby authorize Dr. _____ and his/her associates to provide and/or administer the dental service Silver Diamine Fluoride that he/she or his/her associates deem, in their professional judgement, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment. The most common risks for this treatment can include, but are not limited to:

- *The affected area will stain black permanently. Healthy tooth structure will not stain. Stained tooth structure can be replaced with a filling or a crown.*
- *Tooth-colored fillings and crowns may also discolor if SDF is applied to them. Normally this color change is temporary and can be polished off.*
- *If accidentally applied to the skin or gums, a brown stain may appear that causes no harm, cannot be washed off, and will disappear in 1-3 weeks.*
- *You may notice a metallic taste. This will go away rapidly.*
- *If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such repeat SDF, a filling or crown, root canal treatment, or extraction.*
- *These side effects may not include all of the possible situations reported by the manufacturer. If you notice other effects, please contact your dental provider.*

Silver Diamine Fluoride (SDF) is an antibiotic liquid. We use SDF on cavities to help stop tooth decay. We also use it to treat tooth sensitivity.

Treatment with SDF does not eliminate the need for dental fillings or crowns to repair function or esthetics. Additional procedures will incur a separate level of consent.

I should not be treated with SDF if I am allergic to silver, or there are painful sores or raw areas on my gums (i.e., ulcerative gingivitis) or anywhere in my mouth (i.e., stomatitis).

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates. Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT,
AND ALL MY QUESTIONS WERE ANSWERED:

_____ (signature of patient) _____ (date)

_____ (signature of witness) _____ (date)