Penn Dental Medicine
University of Pennsylvania

Consent for the Use of Protective Stabilization with Recording Where Available

Patient Name_____ Date_____

This form describes and documents your consent for a recommended protective stabilization for the patient that may be recorded for education, quality improvement and safety purposes as described below.

Protective Stabilization

Protective stabilization includes:

- Use of a Papoose Board or similar device designed to reduce unexpected sudden movement which may result in injury of the patient or surrounding individuals (Passive restraint)
- Being restrained by a parent, guardian, and/or dental staff member such as holding a hand(s) or leg(s) to reduce unexpected sudden movement which may result in injury of the patient or surrounding individuals (Active restraint)

Type(s) of Stabilization: ____Passive/Active/Combination_____

Protective stabilization is recommended for the patient because

- ☐ The patient is unable to cooperate due to age or mental/physical disability
- ☐ The safety of the patient, staff, parent or guardian may be at risk without the use of protective stabilization
- ☐ Stabilization during sedation may be needed to help reduce untoward movement
- ☐ Other_____

By signing this consent, I authorize PDM to use the recommended protective stabilization indicated above. I understand that utilization of restraint may upset the patient and that the reason for this recommendation is the safety of the patient or surrounding individuals.

Recording

I understand that Penn Dental Medicine (PDM) may utilize video cameras where available to document the restraint for purposes of quality improvement, education, and patient safety. By signing this consent, I authorize PDM to make such video, audio, and/or digital recordings during treatment that will capture the patient's likeness, voice, and condition in an identifiable manner. These recordings for quality improvement, education, and patient safety purposes will not become part of the patient's medical record and will not be retained after review.

Potential Complications & Alternatives

The possible complications of the use of restraint that have been discussed with me, including bruising or skin abrasion, panic attacks and accidental injuries to the person performing (or the patient) the restraining.

The dentist and I have discussed alternatives to protective stabilization, including:

- Not having any treatment or postponing treatment. Risk of not performing the treatment needed have been discussed with me.

- Treatment in an operating room. Risks associated with treatment under general anesthesia have been discussed with me and PDM may not be the provider for this alternative.
- Treatment with sedation. Risks associated with sedation have been discussed with me and PDM may not be the provider for this alternative.

Duration of Consent

This consent remains in effect through the entire multi-visit treatment plan unless withdrawn. I understand that I can withdraw my consent for the use of stabilization or for recording of stabilization described above at any time, except to the extent it has already been relied upon. If I decide to withdraw my consent for the use of protective stabilization, I will let my dentist know and I will allow the dentist to stabilize the tooth he/she is working on before removing the protective stabilization.

Dentist Signature_____Date:_____
Printed Name:_____

Parent/Legal Guardian Signature:_____Date:_____
Printed Name: _____