CHILDREN'S & WOMEN'S HEALTH CENTRE OF BRITISH COLUMBIA
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Tot2Teen Dental
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BCCH
AUTHORIZATION FOR SURGICAL OPERATION OR DESIGNATED SPECIAL PROCEDURE OR TREATMENT

Re: ______________________________
(NAME OF PATIENT)

With regard to the above-named patient, I, the undersigned do hereby consent to:

A. Treatment with oral rehabilitation
(TREATMENT)

under the direction of Dr. Anita B Gartner DMD ~~M.D./D.D.S.~~

B. The surgical operation or special procedure of Oral examination, cleaning/scaling, fluoride application, x-rays, fissure sealants, white plastic fillings, silver amalgam fillings, stainless steel crowns, pulp treatment, root canal treatment, extractions

under the direction of Dr Anita B Gartner DMD ~~M.D./D.D.S.~~

The nature and anticipated effects of such treatment, surgical operation or special procedure as detailed in A or B above have been explained to me by Dr. Anita B Gartner and I understand the explanation.

I also authorize such additional or alternative treatment, surgical operations or special procedures as, in the opinion of the physician or dentist named in the first paragraph, are immediately necessary.

I further agree that, at his or her discretion, the physician or dentist named in the first paragraph may make use of other surgeons, physicians, dentists and hospital medical staff working under his or her discretion, in the performance of all or part of the surgical operation or special procedure.

I also consent to the administration of anaesthesia and to the use of such anaesthetics as may be deemed advisable by the anaesthetist.

Dated this __________ day of ______________________ 20 _____

____
Signature of Patient

____
Date

X______________________________
Signature of Parent or Legal Guardian

____
Date

____
Witness Name Signature

____
Date

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