PATIENT CONSENT AND AUTHORIZATION
PROCEDURE: IV CONSCIOUS SEDATION

PROCEDURE DISCLOSURE OF SPECIFIC RISKS AND CONSENT

1. I am asking to receive **IV conscious sedation** during my pending procedure/operation/treatment. I want to have sedation in order to lessen the pain I would otherwise experience.

2. I understand that regardless of the type of sedation there are a number of risks and consequences which may occur. The following represent some, but not all, of the risks and consequences which can occur: nausea, vomiting, headache, changes in blood pressure, memory, drug reactions, cardiac arrest, brain damage or death. Other ______________________________

3. I understand that medications that I am taking may cause complications with sedation or surgery. I have informed my doctors about the nature of any medications I am now taking including but not limited to aspirin, appetite suppressants, cold remedies, narcotics, PCP, marijuana, cocaine.

4. I acknowledge the type(s) of sedation recommended for my procedure has/have been explained to me and that in my physician's best medical judgment, he/she will provide the appropriate sedation necessary to complete my procedure/operation/treatment in the safest possible manner.

5. I understand while I am receiving sedation, emergency conditions may develop which require modification or extending this consent. I therefore authorized modifications or extensions of this consent that professional judgment indicates to be necessary under the circumstances.

6. I understand that I must not eat 8 hours prior or drink clear liquids 6 hours prior to my procedure/operation/treatment, UNLESS DIRECTLY PERMITTED BY MY PHYSICIAN.

7. I consent to the appropriate tests and treatments which may better evaluate my risk and prepare me for surgery as part of my medical care associated with this procedure/operation/treatment.

8. I understand that my sedation care will be given to me by or under the supervision of my physician. I understand that along with my physician, other personnel, such as a Registered Nurse, may be involved in my care.

9. I have read and fully understand the above consent for sedation, that the explanations therein referred to were made and that all blanks or statements requiring insertion or completion were filled in and that any inapplicable paragraphs or statements, if any, were stricken before I signed this consent.

I acknowledge that no guarantee or assurances have been made to me concerning the administration of IV Conscious Sedation. I have had the opportunity to discuss my procedure and sedation with the physician concerned and I have received answers to all questions I asked.

PATIENT/REPRESENTATIVE SIGNATURE	DATE	WITNESS SIGNATURE	DATE

If patient is not able to sign for him/her self, the following is to be completed and appropriate signature obtained:
Patient named above is a minor, i.e.____ years of age.
Patient named above is unable to sign due to: ______________________________.

PATIENT IDENTIFICATION:

15195 National Avenue, Suite 100
Los Gatos, CA. 95032
Phone 408-356-0454