



**Consent for Conscious Sedation**

I understand that intravenous sedation will be used during this procedure. This should minimize the discomfort experienced during the procedure. The risks of this medication include those associated with the administration of the medicine by means of an IV which include but are not limited to infection and bleeding.

The risks of the medication itself include but are not limited to the following: low blood pressure, low blood oxygen level, depression of the respiratory drive (breathing problems), and cardiovascular compromise (problems with the heart and blood pressure). Extremely unlikely complications include stroke, severe allergic reaction, and death.

I understand that this is an elective procedure and other treatment options have been explained to me.

I consent to the use of conscious sedation.

Signed \_\_\_\_\_  
(Patient or person authorized to consent for the patient)

Date \_\_\_\_\_

Signed \_\_\_\_\_  
(Witness)

Date \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

Time out process performed prior to procedure \_\_\_\_\_  
Procedure room Tech/MA Signature