

# PATIENT CONSENT FOR SEDATION

The following is provided to inform our patients of the choices and risks involved with having treatment under sedation. There are three choices for pain and anxiety management: local anesthesia alone, conscious sedation (oral sedation or IV sedation), or general anesthesia. Dr. Everett does not administer general anesthesia, however if you feel that you require general anesthesia for your procedure, Dr. Everett can arrange to have an anesthesiologist available for treatment.

Occasionally there are complications from sedation including, but not limited to, pain, hematoma, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, fluctuations in breathing pattern, heart rhythm, and/or blood pressure, etc. The most common side effect of any intravenous (IV) infusion is phlebitis. Phlebitis is a raised, tender, hardened, inflammatory response which can have onset from one day to two weeks after the procedure. The inflammation usually resolves with application of warm, moist heat, yet tenderness and a hard lump may be present up to one year.

Because the medications used for sedation cause drowsiness, which can be increased by the use of alcohol or other drugs, I have been advised not to operate any vehicle or hazardous device or consume alcohol beverages for at least twenty-four (24) hours or longer until recovered from the effects of sedation. I have been advised not to make any major decisions until after recovery from the sedation.

I understand that sedatives and narcotics may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. Everett of a suspected or confirmed pregnancy with the understanding that will necessitate the postponement of sedation. For the same reasons, I understand I must inform Dr. Everett if I am a nursing mother.

I hereby authorize and request Dr. Everett to perform sedation as previously explained to me. I consent, authorize, and request the administration of such sedatives and/or narcotics by any route that is deemed suitable by Dr. Everett for sedation purposes. I further understand and accept the risk that complications may result in hospitalization, brain damage, and/or death. I have been made aware of the risks associated with conscious sedation.

**I certify that I have read and fully understand the above authorization and informed consent to sedation and the explanations referred to above.**

I AM CONSENTING TO:  
CONSCIOUS SEDATION

ORAL CONSCIOUS SEDATION

IV

SIGNATURE:

DATE:

PRINTED NAME:

DATE:

WITNESS:

DATE:

