THE UNIVERSITY OF NEW MEXICO • HEALTH SCIENCES CENTER
UNIVERSITY HOSPITAL

Consent for Intravenous Conscious and/or Deep Procedural Sedation

MY SIGNATURE CONSTITUTES MY ACKNOWLEDGEMENT THAT

I, test (Patient), CONSENT TO AND AUTHORIZE THE UNIVERSITY HOSPITAL, UNM Health Science CENTER, AND (none) (Attending) (none) (Fellow) (none) (Nurse Practitioner) (none) (Resident)

OR DESIGNEE TO PERFORM CONSCIOUS OR DEEP SEDATION AND ANY OTHER OPERATION(S) OR PROCEDURE(S) THAT IN THE JUDGMENT OF THE PHYSICIAN MAY BE ADVISABLE ON THE BASIS OF THE FINDINGS DURING THE COURSE OF SEDATION.

(1) The nature and purpose of conscious or deep sedation is to use intravenous (IV) medications (through a needle in a vein) to provide pain relief during operation(s) or procedure(s).

(2) During sedation an IV will be inserted in my vein (if this has not already been done).Devices will be placed on my skin to monitor my heart rate, blood pressure and the amount of oxygen in my blood. When the medications are given, I will become drowsy. I may or may not remember having the procedure performed. It may become necessary to help me breathe and/or give me additional oxygen. After the procedure is over I will remain sleepy and possibly confused for a period of several hours. During this period I should not operate an automobile or other dangerous equipment and I should not make important decisions. During the entire procedure,one medical person will be in charge of my sedation. Full resuscitative equipment will be available. This includes equipment to intubate me (put a tube in my airway) to help me breathe if this is needed and drugs to treatthe effects of the sedative agents (when appropriate).

(3) The risks, benefits and alternatives to conscious or deep sedation have been adequately explained to me by my physician(s) or surgeon(s) and I have all the information that I desire.

(4) I understand that conscious or deep sedation may involve known risk of complications including: inadequate pain relief, nausea, vomiting, inhaling vomit, slowing or stopping breathing, hypoxia (inadequate oxygenation), brain damage or death. Sedation entails the possibility of other injuries from both known and unknown causes.

(5) Alternative means of treatment have been explained to me including giving less pain medication or going to the operating room for general anesthesia. I understand that general anesthesia has similar risks to conscious or deep sedation but these occur more frequently with general anesthesia. Going to the operating room would delay the procedure.

(6) No guarantee or assurance has been made to me as to the results that may be obtained

(7) I understand I have the right to refuse to have conscious or deep sedation.

(8) I certify that I have read or had read to me this authorization and consent, that all blanks requiring completion were fille filled in before I signed and that I understand and agree to the foregoing.

DATE: _____

TIME: _____

X _____
Patient, Person Authorized to Consent

_____
Relationship

_____
Witness

_____
Interpreter (if utilized)

TEST
MR#: 00000 000000100
DOB: 01/01/19 **AGE** 02 Years
DOE: 12/14/06

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_____ _____
Physician Signature Date / Time