Patient Name: _____

Date of Birth: _____

Informed Consent for IV/IM/Inhalation Anesthesia/Sedation/Analgesia

I. Recommended Treatment

I hereby give consent to Dr. _____ to perform the following procedure(s) on me or my dependent as follows:

☐ Intravenous and/or inhalation general anesthesia (deep sedation)

☐ Intravenous sedation

☐ Intramuscular sedation

☐ Oral sedation

☐ Inhalation analgesia

("Recommended Treatment") and any such additional procedure(s) as may be considered necessary for my well- being based on findings made during the course of the Recommended Treatment. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment. **I understand that I must inform the doctor if I am or may be pregnant, that I must inform the doctor if I am unable to urinate within 6 hours of the procedure, and that I must inform the doctor if I have had food or drink within ____ hours prior to the start of the procedure.**

II. Treatment Alternatives

Alternative methods of treatment have been explained to me, such as: _____

_____

but I wish to proceed with the Recommended Treatment described above.

Patient Name: _____

Date of Birth: _____

III. Risks and Potential Complications

I understand that there are risks and potential complications associated with the administration of medications, including anesthesia, and performance of the Recommended Treatment. These risks and potential complications, include, but are not limited to, the following:

1. Drug reactions and side effects.
2. Pain, redness, swelling, reduced function, bruising and/or bleeding at the injection site(s), which is usually temporary but may be more long-lasting.
3. Nausea and vomiting.
4. Drowsiness.
5. Possible injury to nerves at the injection site(s), resulting in temporary or permanent tingling/numbness/pain (possibly of an electric shock nature) of the areas at or near where the injection was given.
6. Severe, irreversible injury, including death.

Signature: _____ Date: _____

Patient/Parent/Guardian

Relationship (if patient a minor): _____

Witness (signature): _____