



GroupHealth

Informed Consent For Conscious Sedation

Name _____

Consumer Number _____

Date of Birth _____

CHART BASE _____

WASHINGTON STATE LAW GUARANTEES THAT YOU HAVE BOTH THE *RIGHT* AND *OBLIGATION* TO MAKE DECISIONS CONCERNING YOUR HEALTH CARE. YOUR PHYSICIAN CAN PROVIDE YOU WITH THE NECESSARY INFORMATION AND ADVICE, BUT AS A MEMBER OF THE HEALTH CARE TEAM YOU MUST ENTER INTO THE DECISION- MAKING PROCESS. THIS FORM HAS BEEN DESIGNED TO ACKNOWLEDGE YOUR ACCEPTANCE OF TREATMENT RECOMMENDED BY YOUR PHYSICIAN.

- ① I understand that conscious sedation may be a necessary part of the course of treatment of the following condition(s) which has (have) been explained to me: _____.
- ② I have been informed how conscious sedation is performed. I understand that all sedation and anaesthesia medications involve risks of complications and serious possible damage to vital organs such as the brain, heart, lung, liver, and kidney, and that in some cases use of these medications may result in paralysis, cardiac arrest, and/or brain death from both known and unknown causes. I have been informed of possible alternative forms of treatment, including non-treatment:
- ③ I understand that, during the course of the conscious sedation, operation, post-operative care, medical treatment, anaesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than set forth above. I therefore authorize my below-named physician, and his/her assistants or designees, to perform such procedures that are considered necessary and desirable, in their professional judgement. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.
- ④ I consent to the administration of sedation or anaesthesia by my attending physician, by an anaesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary.
- ⑤ I hereby authorize Dr. _____ and/or such associates or assistants as may be selected by said physician to administer conscious sedation to _____.

I CERTIFY THAT MY PHYSICIAN HAS INFORMED ME OF THE NATURE AND CHARACTER OF THE PROPOSED TREATMENT, OF THE ANTICIPATED RESULTS OF THE PROPOSED TREATMENT, OF THE POSSIBLE ALTERNATIVE FORMS OF TREATMENT, AND OF ANY RECOGNIZED SERIOUS POSSIBLE RISKS AND COMPLICATIONS OF THE PROPOSED TREATMENT AND OF ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT.

I CERTIFY I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, I HAVE HAD ALL ASPECTS OF THIS MEDICAL TREATMENT EXPLAINED TO MY SATISFACTION, AND I CONSENT.

I HAVE READ AND UNDERSTAND THIS FORM. I AM THE PATIENT OR THE LEGALLY AUTHORIZED PERSON TO SIGN ON THE PATIENT'S BEHALF.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE

RELATIONSHIP OF LEGALLY RESPONSIBLE PERSON TO PATIENT

Witness: _____

Date: _____

Time: _____

Hospital Record or Outpatient Medical Record/Correspondence Section