SOUTHERN RIVERS
DENTAL

Southern Rivers Consent for Conscious Sedation

This form has been designed to acknowledge your acceptance of treatment recommended by your doctor for **Moderate Conscious Sedation.**

1. I understand that IV conscious sedation is indicated for the course of treatment of the following condition(s) which have been explained to me: _____
_____

2. I have been informed how conscious sedation is performed. I understand that all sedation and anesthesia medications involve risks of complications and serious possible damage to vital organs such as the brain, lungs, liver, and kidneys. In some cases use of these medications may result in paralysis, cardiac arrest, and/or death from both known and unknown causes.

3. I understand that during the course of the conscious sedation, operation, post-operative care, medical treatments, anesthesia or other procedures, unforeseen conditions may necessitate additional or different procedures noted above. I therefore authorize my below named doctor, and his assistants, to perfor such procedures considered necessary and desirable, in their professional judgement. The authority granted under this consent shall extend to the treatment of all conditions that require treatment and are not known to my doctor at the time the procedure is commenced.

4. I hereby authorize Dr. _____ and/or assistants as they may be selected by said doctor to administer conscious sedation to _____

5. 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.

6. I certify that 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 legal authorized person to sign on behalf of the patient.

_____	_____	_____
Patient / Legal Guardian's signature	Date	Time
_____	_____	_____
Relationship to patient	Witness	Date