



INFORMED PATIENT CONSENT FOR SEDATION

Name _____ DOB _____

Address _____

Procedure being completed _____

Questionnaire

Have you ever had an examination which sedatives was used? ☐ Yes ☐ No

If so, did you have a reaction? ☐ N/A ☐ Yes ☐ No

Are you allergic to anything? ☐ Yes ☐ No

If so, please list _____

Are you pregnant or breast feeding? ☐ Yes ☐ No

Do you have a history of:

Cardiac/heart problems ☐ Yes ☐ No Depression, Psychosis, Schizophrenia ☐ Yes ☐ No

Respiratory problems ☐ Yes ☐ No Alcohol or drug abuse ☐ Yes ☐ No

Liver or renal/liver disease ☐ Yes ☐ No Epilepsy ☐ Yes ☐ No

Patient Information

Your doctor has asked us to administer sedation to manage claustrophobia or relief of muscle spasms. By signing this form you are indicating that you have been consulted by a doctor, and have had the procedure and risks explained to you by a Technician or Radiologist. By signing this form you are also indicating you understand that you require someone to accompany you after your appointment.

Patient Consent

I understand and accept the risks involved in this procedure. I hereby consent to the sedation.

Signature _____ Date _____
(Patient)

Name _____
(Interpreter if present)

Signature _____ Date _____
(Interpreter if present)