



CONSULTATION DATE: .....

Patient name: .....

DOB: .....

Proposed treatment under conscious sedation:

.....

Benefits: .....

Risks: .....

Name of assessing clinician: .....

**Consultation**

BP	/
SpO2	%
Pulse	
BMI	
Checked for peripheral access	

**Patient declaration**

- I understand that the proposed treatment is due to be carried out under intravenous sedation
- I understand that I may have a light meal 2 hours prior to my treatment appointment
- I understand that I must be accompanied by a competent adult to my treatment and should remain within the building throughout the course of my treatment. If no adult is present my treatment may be cancelled with loss of deposit
- Following my return home I must remain accompanied by a competent adult and for the rest of the day and overnight
- Following my treatment I should travel home by private car or taxi and for the next 2 hours I should not operate any machinery, drink alcohol, take recreational drugs or sign any legally binding documents
- I have been given an instruction leaflet with regards to my treatment and the sedation and had the opportunity to ask any relevant questions.

Patient name (PRINT): .....

Signature: .....

Date: .....