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DUKE UNIVERSITY MEDICAL CENTER

CONSCIOUS SEDATION CONSENT FORM

AA0000
NAME , PATIENT

I PATIENT NAME (patient/parent/guardian) authorize the administration of sedative medication,

Versed / Fentanyl (sleep medicine) to PATIENT NAME (patient) while

the procedure Transvaginal Oocyte Retrival is being performed.

I understand that sedative medication(s) will be given to me (or my child) under the supervision of the physician(s) responsible for performing the procedure. I also understand that the use of sedative medication could result in unexpected problems. These problems include, but are not limited to, pneumonia or other lung problems, breathing difficulties, drug side effects, reversible or permanent brain damage, and death. I understand that unexpected changes in my (or my child's) condition may arise during the procedure. If that happens, I authorize any additional procedures or therapies deemed necessary by the responsible physician.

I understand that the sedative medication is necessary for my (or my child's) comfort and safety during the procedure. It may not be possible to perform the procedure without the use of these medications. Alternatives to the use of conscious sedation may vary depending on the type of procedure. These include no sedation or the relaxation therapies, general anesthesia (putting you to sleep) or local anesthesia as administered by your anesthesiologist.

I have had the opportunity to ask questions. The answers and additional information provided to me are satisfactory. I may withdraw this consent at any time prior to the administration of the sedative medication.

Comments: _____

Signature patient/parent/guardian: _____

Signature M.D.: _____ Pager ID #: _____

Date: _____ Time: _____

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