MEDICAL PROCEDURE CONSENT
EVIDENCE OF INFORMED CONSENT FOR MRI SEDATION

1, PROCEDURE AND ALTERNATIVES: _____, (patient or guardian) authorize Dr.Solsberg
And/or such Assistants as may be selected by him/her to perform CONSCIOUS SEDATION for MRI
I understand the reason for the procedure is: Reduce Anxiety or pain. Alternatives include: TRY MRI WITH NO SEDATION. OPEN MRI SCAN. CT SCAN OR ULTRASOUND MAY BE USED IN CERTAIN SITUATIONS AS AN ALTERNATIVE TO MRI.

2. RISKS: This authorization is given with the understanding that any procedure involves some risks and hazards. The more common risks include: nausea, vein irritation or infection from injection, nerve or vessel injury, headache, drowsiness and allergic reactions. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular procedure include: Systemic effects of analgesics and sedatives such as irritability and insomnia. Reaction to medication that might even be life threatening.

ANESTHESIA: The administration of anesthesia also involves risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such anesthesia as may be considered by the person responsible for these services.
ADDITIONAL PROCEDURES: If my physician discovers a different, unsuspected condition at the time of procedure, I authorize him/her to perform such treatment, as he/she deems necessary. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

6. I consent to the above procedure(s) being witnessed by students or other practitioners in the health sciences in connection with their continuing education.
7. I authorize Dr SOLSBERG and designated staff to preserve and examine for scientific, pathological or teaching purposes, or to otherwise dispose of the tissue or fluids resulting from the procedure(s) authorized above.
8. **PHOTOGRAPHS:** The undersigned hereby authorizes the taking of photographs or movies during the procedure to be used only for purposes of medical study or research. This consent is expressly intended to release from liability all personnel as well as the radiologist, consultants and the attending physician.
9. **PATIENT'S CONSENT:** I have read and fully understand this consent form, and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED PROCEDURE OR TREATMENT, ASK THE PHYSICIAN NOW; BEFORE SIGNING THIS CONSENT FORM. DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Witness **Patient, or Guardian for Patient**

Date **Time (AM-PM)**

10...PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

Physician's Signature **Date** **Time (AM-PM)**