BACK BAY IMAGING

301 Bayview Circle, Suite 105
Newport Beach, CA 92660
ph (949) 799-3000
fax (949) 799-4000
info@backbayimaging.com

Oral Sedation Consent

Name _____ **WI#** _____

Age _____ **Weight** _____**lbs.** **Height** _____‘_____“

Exam _____ **Arrival Time**_____ **Scheduled Time** _____

Have you ever taken any of the following (Circle)? XANEX VALIUM VERSED ATIVAN

Have you had an allergic reaction to any of them? ☐ Yes ☐ No

If yes, please describe _____

Are you allergic to any other medications? ☐ Yes ☐ No

If yes, please describe _____

I consent to receive oral Ativan for the purpose of sedation during my procedure at Back Bay Imaging. I am fully aware that I must have a responsible driver to transport me to and from the Back Bay Imaging as this medication can possibly affect my driving ability.

_____ _____
SIGNATURE* DATE

_____
WITNESS

*Patient or Patient Representative: Parent/Conservator/Guardian

FOR OFFICE USE ONLY

Initial Dose _____mg **Subsequent Dose (if needed)** _____mg

Radiologist Signature _____

Initial dose Ativan given by _____ **Time** _____ **Date** _____
BACK BAY IMAGING REPRESENTATIVE

2nd dose Ativan given by _____ **Time** _____
BACK BAY IMAGING REPRESENTATIVE