NSN 7540-00-634-4176 600-1

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	GASTROENTOROLOGY CLINIC

I _____ **(print first and last name)** am aware that I will be given conscious sedation and will be unable to drive post procedure. I am required to have a driver that remains present on this installation throughout the procedure in order to take me home once it is complete. If I choose to take the bus or trolley, I will need to provide an escort to assist until my procedure is complete. It is my responsibility to make sure that I provide a driver/escort that will stay at the hospital through the duration of my procedure, and is aware that they cannot leave the hospital grounds until my procedure is complete. If I am unable to provide a driver/escort on the day of my procedure, I will have to either reschedule my appointment or opt to complete without sedation.

x _____ **(signature)**

RECORDS MAINTAINED AT:		
SPONSORS NAME		ORGANIZATION
DEPT/SERVICE	SSN/IDENTIFICATION	DATE OF BIRTH