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CONSENT FOR ANESTHESIA

I, ____, have been scheduled for and consented to an endoscopic procedure. I understand that anesthesia services are needed so that my doctor can perform the procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. ALTHOUGH RARE, SEVERE UNEXPECTED COMPLICATIONS CAN OCCUR WITH ANESTHESIA, INCLUDING THE POSSIBLITY OF INFECTION, BLEEDING, DRUG REACTIONS, BLOOD CLOTS, LOSS OF SENSATION, LOSS OF VISION, LOSS OF LIMB FUNCTION, PARALYSIS, STROKE, BRAIN DAMAGE, HEART ATTACK OR DEATH, I understand that these risks apply to ALL forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type of anesthesia service described below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, as well as my own desires.

Monitored Anesthesia Care (with sedation)
Drugs are injected into the bloodstream, producing a state of reduced anxiety and pain, with partial or total amnesia. Risks include the possibility of depressed breathing, nausea or vomiting, injury to blood vessels, aspiration of stomach contents, and/or the need for general anesthesia (total unconscious state which may necessitate the placement of a breathing tube into the windpipe).

I hereby consent to the above anesthesia service and authorize that it be administered by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) under the supervision of an Anesthesiologist, all of whom are credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I certify that I have read or have had it read to me and fully understand the above consent which has been preceded by an explanation from a representative of the Anesthesia Department. I acknowledge that I have been adequately informed concerning material risks, complications, expected results, and possible alternatives, including not having anesthesia, and specifically consent to such. I certify and acknowledge that I had ample time to ask questions and to consider my decisions.

____ ____________ ____________

Signature of Patient/legal guardian or sponsor (relationship) ***Date*** ***Time***

____

Witness to signature

ATTESTATION STATEMENT: The above patient/legal guardian has been counseled regarding the material risks and possible complications associated with the proposed anesthesia service, and the benefits and alternatives to the proposed anesthesia service.

____ ____________ ____________

Signature of Counseling Physician/CRNA ***Date*** ***Time***