Liberty Endoscopy

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Consent for Anesthesia Services

I, <Patient name> , 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, unexpected *severe complications* with anesthesia can occur and include the remote possibility of *infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, dental damage, 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 I will receive may be local, minimal, moderate, or deep sedation.

The anesthetic agent to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. The drugs used will be injected into the bloodstream producing a semiconscious state. The expected result is to reduce anxiety, pain, and provide partial or total amnesia**.**

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 certify that I have read, received adequate explanation, had ample time to ask questions, had ample time to consider my decisions, and fully understand the above consent. Having this knowledge and no further questions, I affix my signature below and authorize the delivery of anesthesia services for my surgical procedure.

Signature of Patient/legal guardian or sponsor

<Patient_Sig>

Witness to signature

<Witness2_Sig>

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

<Anes_Sig>

Today's Date: <Today's Date>