CONSENT FOR ANESTHESIA SERVICES

I, _____, have been scheduled for _____ (operation/procedure). I understand that anesthesia services are needed so that my doctor can perform the operation or procedure.

I understand that the type(s) of anesthesia service checked 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 to be performed, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique that involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia. 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 EACH TYPE OF ANESTHESIA, INCLUDING THE POSSIBILITY OF INFECTION, BLEEDING, DRUG REACTIONS, COGNITIVE DYSFUNCTION, BLOOD CLOTS, LOSS OF SENSATION, BLINDNESS, 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.

The type of anesthesia I will be receiving is:

☐ Sedation	Expected Results	This can vary in depth from mild to moderate to deep.
	Technique	One or more hypnotic or sedative drugs will be given intravenously with the goal of reduced consciousness and total or partial amnesia. These drugs may include those normally introduced for general anesthesia, however, in modified dosage and administration to achieve sedation.
	Risks (include but not limited to)	Depressed breathing, vomiting, aspiration, unconscious state, injury to blood vessels
☐ Monitored Anesthesia Care (without sedation)	Expected Result	Measurement of vital signs, availability of anesthesia provider for further intervention.
	Technique	None.
	Risks (include but not limited to)	Increased awareness, anxiety, discomfort and/or pain.

I consent to the anesthesia service checked above and authorize that it be administered by [ANESTHESIA GROUP] through an anesthesia care team, including Certified Registered Nurse Anesthetists under the supervision of an Anesthesiologist, all of whom are credentialed to provide anesthesia services at this health care facility. In addition to the anesthetic discussed above, I also consent to alternative types of anesthesia, if necessary, as deemed appropriate by the anesthesiologist providing my care.

I acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decisions.

_____ _____
Patient's Signature *Date and Time*

_____ _____ _____
Anesthesia Provider's Signature *Substitute's Signature* *Relationship to Patient*