BROAD ANESTHESIA ASSOCIATES

CONSENT AND REQUEST FOR ADMINISTRATION OF ANESTHESIA

Procedure: ☐ **Esophagogastroduodenoscopy** ☐ **Colonoscopy** ☐ **Flexible Sigmoidoscopy**

Planned Anesthesia: **Monitored Anesthesia Care**

I hereby understand that it will be necessary to be placed under anesthesia in order to perform the above described procedure and I consent to the use of anesthesia as deemed necessary and appropriate by my anesthesiologist, surgeon, and nurse anesthetist with **the exception to the following kind of anesthesia:**

☐ None _____

Anesthesia involves risk in addition to the risk of the surgical procedure itself. These risks may include, but are not limited to: adverse drug reactions; brain damage; neurological damage; nerve injury; damage to teeth or dental work; damage to vocal cords; respiratory complications; damage to arteries or veins; headaches; backaches; minor pain and discomfort; worsening of pre-existing disease(s); and / or death.

The purpose, necessity, and risks of anesthesia and the identity of those individuals who will render my anesthesia care have been disclosed to me to my satisfaction by

_____MD/CRNA.

I understand that it is my responsibility to discuss previous problems with anesthesia, allergies, medications and any other problems that I may have had, which would affect the outcome. I further warrant that there has been sufficient opportunity to discuss the proposed treatment, associated risks and alternative treatments.

No guarantee or warranty has been made as to the result of the anesthetic procedures.

I declare and represent that I have read the above and understand it is true.

_____
Patient Signature (Authorized Person)

_____
Witness Signature

_____
Date and Time

_____
Anesthesiologist Signature

INS:
DOS:
DR:
ACT#:
DOB: AGE:
NAME: