endoscopy center of niagara

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Patient Name: **<Patient name>**
MRN: **<Patient ID>**
DOB: **<Birthdate> (<Age>)**
Gender: **<Gender>**
Date: **<Today's Date>**
Physician: **<Performing MD>**
Procedure: **<Scheduled Procedures>**

CONSENT FOR ANESTHESIA SERVICES

I acknowledge that my doctor has explained to me that I will have a procedure. I also 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 risk and, although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, aspiration, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, heart attack, or death. I understand that these risks apply to all forms of anesthesia and the additional or specific risks have been explained and have been identified below. I understand that the type(s) of anesthesia services checked below will be used for my procedure and that the technique to be used is determined by many factors including my physical condition, the type of procedure to be performed, as well as my physician's and my own preference.

Plan for Anesthesia: <Plan>

Monitored Anesthesia Care (*with sedation*)	Expected Results	Reduced anxiety and pain, partial or total amnesia
	Technique	Drug injected into the bloodstream or by other routes producing a semiconscious state
	Risks	An unconscious state, depressed breathing, injury to blood vessels
Monitored Anesthesia Care Moderate (Conscious) Sedation	Expected Results	Reduced anxiety and pain, partial amnesia, no anticipated loss of consciousness
	Technique	Drug injected into the bloodstream or by other routes producing a semiconscious state
	Risks	An unconscious state, depressed breathing, injury to blood vessels
Monitored Anesthesia Care (*without sedation*)	Expected Results	No change in consciousness or mental status
	Technique	Monitoring of vital signs
	Risks	Possibility of discomfort associated with procedure

I hereby consent to the anesthesia service indicated above and authorize that it be administered by the Anesthesia Provider. I certify and acknowledge that I have read this form, that I understand the nature, benefits, risks, alternatives, and expected results of the anesthesia service, and that I had ample time to ask questions and consider my decisions.
<Patient_Sig>
<Witness_Sig>
<Physician_Sig>
<Anes_Sig>