South Brooklyn
ENDOSCOPY CENTER

INFORMED CONSENT FOR CLINICAL ANESTHESIA

Today's Date: _____

Patient Name: _____
MRN:
Date of Birth: _____

Scheduled Procedure(s): _____

Performing Physician:_____
I. I hereby authorize the anesthesia provider to provide clinical anesthesia to myself.

II. The anesthesia provider has explained to, and discussed with me the nature and purpose of the proposed anesthesia. This consists of placing a catheter into my vein and administering medicine. My vital signs will be continually monitored throughout the procedure—blood pressure, electrocardiogram, oxygen saturation, respiration and pulse.

III. I consent to the administration of intravenous anesthesia and the inhalation of oxygen under the direction and/or supervision of the anesthesia provider.

IV. The anesthesia provider has explained and discussed with me the items that are summarized as follows:

Monitored Anesthesia Care (with intravenous sedation)
Drugs are injected into the bloodstream, producing a state of reduced anxiety and pain, with partial or total amnesia.

A. The pre procedure, procedure and post procedure risks of anesthesia include but are not limited to inflammation of the vein, bruising and /or discoloration at the injection site, spasm of the muscles of the face, lack of coordination, drowsiness, fainting, allergic reactions, vomiting, nausea, damage to teeth or oral tissues, necrosis of tissue at the injection site, brain damage, paralysis, cardiac arrest and/or death.

B. The possible or likely results of intravenous anesthesia are to keep me in a sedated or sleep like state.

C. All feasible alternatives to the administration of intravenous anesthesia have been adequately explained by the anesthesia provider.

D. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment and/or anesthetic.

Monitored Anesthesia Care (without intravenous sedation)
Vital functions are measured and supported, and the anesthesia team is present and available for further intervention as deemed necessary to complete the procedure safely. Risks include, but are not limited to anxiety, pain and/or discomfort.

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V. I attest that I have not consumed any solid food since midnight and liquids six hours prior to the time of the procedure.

VI. I have had sufficient time to discuss benefits and risks of anesthesia with the anesthesia provider.

VII. All of my questions have been answered satisfactory by the anesthesia provider.

VIII. I certify that I have read and fully understand the above consent statement which has been preceded by an explanation by my anesthesia provider.

IX. I consent knowingly and voluntarily to the administration of intravenous anesthesia as outlined above. At all times during the reading, explanation, and execution of this form, I possessed all of my mental faculties and was not under the influence of alcohol and/or medications.

X. South Brooklyn Endoscopy Center/Digestive Diseases Diagnostic and Treatment Center will bill my insurance carrier when applicable. I hereby authorize my insurance benefits to be paid directly to South Brooklyn Endoscopy/Digestive Diseases Diagnostic and Treatment Center and acknowledge and accept full financial responsibility for my account balance. So. Brooklyn Endoscopy Center/Digestive Diseases Diagnostic and Treatment Center will abide by all regulations of participating insurance plans.

Patient_____**Signature**_____**Date/Time**_____

Legal Guardian_____**Signature**_____**Date/Time**_____

Witness_____**Signature**_____**Date/Time**_____

Anesthesia Provider _____**Date/Time**_____