PATIENT CONSENT FOR ANESTHESIA

I authorize and direct _____ , M.D. and/or his/her associates to perform anesthesia upon me and/or to do any other procedure that in his/her judgement may be advisable for my well being. These may include General, Local, Regional or Monitored Anesthesia Care. Anesthesia involves the use of drugs and procedures. The I.V. medications given also have amnesic properties, that is, they may make you forget surgery. Not only do different individuals react differently to the same medications, but also the state of their physical health influences the action of medications. While all reasonable precautions will be taken, unforeseen reactions or complications may occur.

I understand and accept the fact that certain hazards and risks are inherent in any anesthetic procedure. Post anesthetic nausea and vomiting, headache, phlebitis, or sore throat with laryngeal and tracheal swelling may occur. Even though steps are taken to protect bridgework, capped or unsound teeth, there is no guarantee against possible accidental damage, even to normal teeth.

More serious heart and lung abnormalities or nerve and/or muscle disorders also may occur. No anesthetic procedure, general, local, spinal, epidural, or other, is any guarantee against the development on any complications. Although rare, there is always a remote risk of death, paralysis, or brain damage associated with the administration of anesthetics and no warranty or guarantees have been made as to the outcome.

_____

PATIENT SIGNATURE DATE WITNESS TIME

_____

PARENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE DATE WITNESS TIME

(If the patient is a minor or unable to sign, complete the following)

- ❑ Patient is a minor
- ❑ Patient is unable to sign because: _____

PATIENT IDENTIFICATION:

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