CONSENT FOR CONSCIOUS SEDATION OR GENERAL ANESTHESIA

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have chosen (circle one) **conscious sedation or general anesthesia** for your treatment. You have the right to be informed about this so that you can decide whether to have it or not after knowing the risks and benefits. These common procedures are considered quite safe. Nevertheless, all procedures have some risks. They include the following and others:

_____1. Discomfort, swelling or bruising where the drugs are placed into a vein.

_____2. Vein irritation, called phlebitis, where the drugs are placed into a vein. Sometimes this may grow to a level of discomfort or disability where it may be difficult to move your arm or hand. Sometimes medication or other treatment may be needed.

_____3. Nerves travel next to the blood vessels where the drugs are placed into a vein. If the needle hits a nerve or if drugs or fluid leaks out of the vessel around a nerve, I may have numbness or pain in the nerve where it runs along the arm. Usually the numbness or pain goes away, but in some cases, it may be permanent

_____4. Allergic reactions (previously unknown) to any of the medications used.

_____5. Nausea and vomiting, although not common, are possible unfortunate side effects. Bed rest, and sometimes medications, may be required for relief.

____ 6. Conscious sedation and general anesthesia are serious medical procedures and, whether given in a hospital or office, carry the risk of brain damage, stroke, heart attack or death.

YOUR OBLIGATIONS:

_____7. Because anesthetic or sedative medications (including oral premedication) causes drowsiness that lasts for some time, I MUST be accompanied by a responsible adult to drive me to and from surgery, and stay with me for several hours until you are recovered sufficiently to care for myself. Sometimes the effects of the drugs do not wear off for 24 hours.

_____8. During recovery time (normally 24 hours), I should not drive, operate complicated machinery or devices or make important decisions such as signing documents, etc.

_____9. I must have a completely empty stomach. It is vital that I have NOTHING TO EAT OR DRINK for **six (6) hours** prior to your treatment. TO DO OTHERWISE MAY BE LIFE-THREATENING.

_____10. **Unless instructed otherwise**, it is important that I take any regular medications (high blood pressure, antibiotics, etc.) or any medicines given to me by my surgeon **using only a small sip of water**.

CONSENT

I have read and understand the above paragraphs and realize that conscious sedation or general anesthesia have certain serious risks. I request that my choice be used for my treatment. I fully understand the risks involved. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date