Odessa Endoscopy Center

Anesthesia Consent

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

Anesthesia professional may provide care to you to help control your pain and discomfort during your procedure. In consultation with the physician performing your procedure today and in consideration of many factors including your physical condition, the type of procedure being performed, your physician's preference, and your input, the Anesthesia Provider indicated below will be using Total Intravenous Anesthesia, commonly called IV sedation or MAC (Monitored Anesthesia Care)

All forms of anesthesia involve some risks and we can make no guarantees or promises concerning the results or outcome of the anesthesia plan of care. Some of the more common drawbacks and complications of anesthesia include: swelling, bleeding, or discomfort at the site of the injection; allergic reactions to the anesthetic agents; nausea and vomiting; permanent organ damage; memory dysfunction/memory loss; and prolonged recovery from anesthesia. Although rare, unexpected severe complications may occur including difficulties breathing, cardiac arrest, and death.

If you have ever had a severe allergic reaction to ANY substance or environment (including latex or a bee sting) you must tell your physician and the Anesthesia Provider before we give you medication or other substances.

Please read carefully and sign below if you understand and consent to the following:

I consent to the anesthesia plan of care as described to me and authorize that it be administered by the Anesthesia Provider who has signed below or his / her associates, all of whom are credentialed to provide anesthesia services at Odessa Endoscopy Center. I also consent to any other procedures that, in the judgment of my anesthesia provider and my physician, may be necessary for my wellbeing, including such interventions as are considered medically advisable to remedy conditions discovered during the operation or procedure. I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service, that no guarantees have been made as to the outcomes of the plan of care, and that I have had ample time to ask questions and to consider my decision.

Patient Signature_____**Date**_____**Time**_____

Witness Signature_____**Date**_____**Time**_____