INFORMED CONSENT FOR ANESTHESIA SERVICES

I have a general understanding of the procedure to be performed by my physician. I understand anesthesia services are requested or needed for the procedure. I consent to the administration of anesthesia as required for the procedure. I authorize the anesthesia provider Raleigh Sedation Associates, LLC to provide anesthesia services as part of my upcoming procedure. I understand and acknowledge that all forms of anesthesia involve some risks and side effects, and the anesthesia provider can make no guarantees or promises concerning the results or outcome of the anesthesia plan of care. I acknowledge that impairment of full mental alertness may persist for several hours following the administration of anesthesia, and will avoid making decisions or taking on activities, which depend on full concentration or judgment during this period.

It has been explained to me all forms of anesthesia have some risks and side effects. Although rare, unexpected severe complications can occur. Possible anesthetic complications include but are not limited to, swelling, bleeding or discomfort at the site of injection; phlebitis or other damage to blood vessels; nerve damage, infection, bleeding, drug interactions, allergic reactions, dental damage, stroke, brain damage, heart attack, cardiac arrest or death. Complications may require hospitalization. I understand that these risks apply to all forms of anesthesia; additional or specific risks are identified below, as they apply to each type of anesthesia.

I understand the section below details the types of anesthesia to be used for my procedure. I understand the anesthetic technique is determined by many factors including my physical condition, the procedure performed, the physician preference, anesthesia provider plan of care or my own desires. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the anesthesia provider and physician.

General Anesthesia: a controlled, drug-induced state of unconsciousness, accompanied by partial or complete loss of protective reflexes Including an inability to independently maintain an airway and/or respond purposefully to physical stimulation or verbal command. May require a placement of breathing tube in the windpipe or another breathing device. Risks include, but not limited to, mouth or throat pain, hoarseness, injury to mouth or teeth, awareness of intraoperative events, injury to blood vessels, aspiration and pneumonia.

Deep Sedation: a controlled, drug induced state of depressed consciousness from which the patent is not easily aroused, which may be accompanied by partial loss of protective reflexes, including the ability to maintain an open airway independently and/or respond purposefully to physical stimulation or verbal commands. Risks include, but not limited to, infection, mouth or throat pain, hoarseness, injury to mouth or teeth, aspiration, dizziness, nausea or vomiting can occur.

Monitored Anesthesia Care (MAC): Anesthesia providers are present and able to provide indicated care based on my response to the procedure. Medications utilized may be sedatives, narcotics, and/or anesthetics and the degree of sedation or anesthesia cannot be specified ahead of time.

I understand the possible risk and complications of the planned anesthesia care as they have been explained to me. I have had the opportunity to ask questions, and I understand what has been explained. I hereby consent to anesthetic(s) above and authorized the credentialed anesthesia providers of this facility to provide the outlined anesthesia plan. I further understand and certify for my own safety, I have a responsible adult to take me home after my procedure.

_____	_____	_____
Patient and/or legal Guardian's signature	Relationship	Date/Time

_____	_____
Witness to above Signature	Date/Time

Anesthesia Provider Statement: I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the anesthesia and have allowed time for the patient/responsible adult to ask questions.

_____	_____
Anesthesia Provider	Date/Time

<Patient name>
<MRN>
<DOB>