

**Springfield Ambulatory Surgery Center
1528 Bethlehem Pike
Flourtown, PA 19031
215.402.0600**

Date:

Patient:

DOB:

SSN:

Doctor:

ANESTHESIA CONSENT

I authorize the monitoring of vital bodily functions and the administration of the anesthetics to myself under the direction of a staff member of the Department of Anesthesia at the Springfield Ambulatory Surgery Center. I have had explained to me and I permit the administration of one or more of the following forms of anesthesia that may be suitable for the procedure I am about to have:

_____ MONITORED ANESTHESIA CARE, including intravenous agents, which will render me unaware and insensate to the pain of the procedure.

I understand that during the course of the operation or procedure, unforeseen changes in my condition may arise, which would necessitate changes in the care being provided to me. In that case, I authorize the anesthesiologist to perform any additional procedures deemed medically necessary.

Common side effects of anesthesia include: nausea and vomiting, headache, backache, sore throat, or hoarseness, and soft tissue swelling. In addition, even minor surgery may carry with it unforeseen anesthetic risks. These risks and complications include but are not limited to dreams or recall of intraoperative events, eye injuries, damage to the mouth, teeth or vocal cords, pneumonia, numbness, pain or paralysis, local bleeding or infection, damage to veins, arteries, liver or kidneys, adverse drug reaction and, in rare cases, nerve injury or paralysis, permanent brain damage, heart attack, stroke or death. These potential risks apply to me whether I have general, regional, or local anesthetic.

I acknowledge that I have, to the best of my ability, told the anesthesiologist obtaining my consent of all major illnesses I have had, of all past anesthetics I have received and any complications of these anesthetics known to me, of any drug allergies I have, and of all medications I have taken in the past year. I have also responded truthfully to any questions asked by the anesthesiologist.

The nature and purpose of my anesthetic management have been explained to me, along with the risks, benefits, and alternatives. I have had the opportunity to ask questions, and the answers and additional information provided have met with my satisfaction. I retain the right to withdraw this consent at any time prior to the administration of said anesthetic.

Comment: _____

Signature: _____ Date _____
Patient or Responsible Person

Signature: _____ Date _____
Physician