

PENN VALLEY ANESTHESIA ASSOCIATES, LLC.
CONSENT FOR ANESTHESIA

I, _____, acknowledge that my doctor has explained to me that I will have an operation , diagnostic or treatment procedure. I also understand that anesthesia services are needed so that my doctor may perform the operation or procedure. It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug interactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific anesthetic technique. I understand that the type(s) of anesthesia service described below, may be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do. It has also been explained to me that during the course of an anesthetic technique involving sedation, it is possible that the level of sedation may progress to a deeper anesthetic state which might require general anesthesia.

- **MONITORED ANESTHESIA CARE WITH SEDATION:** State of reduced anxiety and pain, with partial or total amnesia. Risks include the possibility of an unconscious state, depressed breathing, injury to blood vessels and aspiration of stomach contents.
- **GENERAL ANESTHESIA:** Total unconscious state which may necessitate the placement of a breathing tube into the windpipe. Risks of mouth or throat pain, hoarseness, injury to teeth or mouth, awareness under anesthesia, injury to blood vessels and aspiration of stomach contents.

I, hereby consent to the anesthesia services checked above and authorize it to be administered by **PENN VALLEY ANESTHESIA ASSOCIATES, LLC.** I certify that I have read this form or had it read to me, that I understand the risks, alternatives, and the expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment and or anesthetic. In addition I agree to the following.

- I certify that a responsible adult will drive me home and stay with me for the next 8 hours.
- I will not drive a car or consume alcohol for at least 24 hours.
- I certify that all information provided to PENN VALLEY ANESTHESIA ASSOCIATES, LLC. concerning my anesthesia has been truthful and accurate and I have not consumed any solid food 8 hours prior or liquids 3 hours prior to my procedure.
- I understand that if any problems arise post-operatively, I am to call my surgeon and or PENN VALLEY ANESTHESIA ASSOCIATES, LLC.

Patients Signature

Date and Time

Substitutes Signature

Relationship to the Patient

Witness / Date and Time _____

****** I herby deny that there is any chance that I may be pregnant and I waive my right to a Pregnancy test prior to this Procedure Patient Signature: _____**