Endoscopy Center of Bucks County

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CONSENT FOR ADMINISTRATION OF ANESTHESIA

_____ is scheduled for the following medical
Patient Name

procedures: _____ EGD with sedation _____ Flexible Sigmoidoscopy with sedation

_____ Colonoscopy with sedation _____ Other: _____

I understand that anesthesia will be administered and that anesthesia involves risks, which may include adverse drug reactions, nerve injury (ies), paralysis, brain damage or death. Additional risks from anesthesia may include such things as injury to teeth or dental work, damage to vocal cords, respiratory problems, pain and discomfort, nausea and vomiting, damage to arteries and veins and headaches.

To the best of my knowledge, all of the answers to the questions I have been asked are true and I have not withheld any information.

I have had the above risk(s) associated with the administration of anesthesia explained to me in terms that I understand. I also have had the opportunity to discuss alternatives. My questions have been answered to my satisfaction. Therefore, **I hereby consent to the administration of the necessary pre-operative and post-operative medications.**

_____ _____
(Signature of PATIENT) (Signature of WITNESS)

_____ _____
(Signature of AUTHORIZED REPRESENTATIVE) (RELATIONSHIP to Patient)

ANESTHESIA DEPARTMENT:

_____ Date: _____ Time: _____
(Signature & Title)