

CONSENT FOR ANESTHESIA SERVICES

Patient Name _____

Date _____

You have chosen to undergo an elective, cosmetic procedure. I understand that anesthesia services are needed so my doctor can perform the procedure.

_____ It has been explained to me that **all** forms of anesthesia involve some **risks**. Although rare, unexpected **severe complications** with anesthesia can occur and include the remote possibility of **infection, bleeding, drug reactions, 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 type of anesthesia. I understand that the type of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including but not limited to my physical condition, the type of procedure **Dr. Heir** is to do, his own preference, as well as my own desire.

General Anesthesia

Expected Result	Total unconscious state, possible placement of a tube into the windpipe (trachea) if necessary.
Technique	Drug injected into the bloodstream via IV, breathed into the lungs, or by other routes.
Risks	Mouth or throat soreness, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, nausea, vomiting, aspiration, pneumonia, or delayed awakening.

Monitored Anesthesia Care With Sedation

Expected Result	Reduced anxiety and pain, partial or total amnesia.
Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state.
Risks	An unconscious state, depressed breathing, injury to blood vessels, nausea, and vomiting.

Patient Obligations:

- _____ 1. Because the anesthetic medication causes prolonged drowsiness, a responsible adult **MUST** accompany you to drive you home and stay with you for several hours until you are recovered sufficiently to care for yourself. Sometimes the effects of the drugs do not wear off for 24 hours.

- _____ 2. During recovery time (normally 24 hours), you should **not** drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
- _____ 3. You must have a completely empty stomach. It is vital that you have nothing to eat or drink for eight (8) hours prior to your procedure unless otherwise directed by the anesthesia provider.
- Note:** If directed by your doctor, sips of water may be used to take regular medications or prescriptions given to you by this office.

_____ I have read and understand the above paragraphs and realize that all forms of anesthesia involve some risks. I hereby consent to the anesthesia service checked above and authorize that it be administered by **Dr. Heir** or his/her associate(s), _____, all of whom are credentialed to provide anesthesia services at **Sacramento Surgical Arts**. I certify and acknowledge that all of my questions regarding this consent have been answered fully and to my satisfaction, and fully understand the risks involved. I also state that I read, speak, and write English.

Patients or Legal Guardian's Signature

Date

Witness' Signature

Date

Doctor's Signature

Date