CONSENT FOR

ANESTHESIA SERVICES

Patient Name:____Date__________________________

Please initial each paragraph after reading,
If you have any questions ask Dr. Rochlin BEFORE initialing.

You have chosen to undergo an elective, cosmetic procedure. I understand that anesthesia services are needed so your 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 the following but not limited to the following **infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, pneumothorax, 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 my physical condition, the type of procedure Dr. Rochlin is to do, her own preference, as well as her own desire.

______**General Anesthesia**

_______Expected Result: Total unconscious state placement of a tube into the windpipe.

_______Technique: Drug injected into the Bloodstream and 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, aspiration, pneumonia.

_____**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

______Risks an unconscious state, depressed breathing, injury to blood vessels.

I have been informed of the common complications listed on this page (initial) ____

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 will be

Administered by ____

Or his/her associates, all of whom are credentialed to provide anesthesia services at Estetica Cosmetic and Reconstructive and Surgery Center. 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.

Confirm with my signature below that: the physician has discussed the above information with me, that I have had the chance to ask questions, that all my questions have been answered to my satisfaction, and that I thereby give informed consent. I voluntarily request treatment with by the physician, which has been explained to me, and my questions regarding such treatment, its alternatives, its complications and risk have been answered by the doctor, staff, and/or written information. My questions have been fully and completely answered for me and I have read this document and understand its contents. I hereby give my unrestricted informed consent for the procedure. In the event a dispute arises over the outcome of my procedure, I consent solely to arbitration as a legal means of settlement.

____
Patients Signature Date

____
Witness Signature Date

____
Anesthesia Date

Physician Only: I confirm with my signature that I have made time available to discuss with the above-named patient the risks, potential complications, and intended benefits of surgery The patient has had the opportunity to ask any questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested to perform surgery on him/her.

Physician signature: ______________________ Date: ______________

Our patients are offered a copy of any form they sign