Endoscopy Center of Ocean County / Endoscopy Center of Toms River
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INFORMED CONSENT FOR ANESTHESIA

I, **SAMPLE ONLY- DO NOT SIGN**, understand that the anesthesiologist and/or the physician, will be

Administering to me for my procedure, either:

- Monitored Anesthesia Care (MAC)
- Moderate Sedation (Conscious Sedation)

I understand the Monitored Anesthesia Care involves the administration of IV medication to achieve a state of relaxation sufficient to improve tolerance for the procedure but not intended to result in significant depression of breathing or total inability to respond.

I understand that Moderate Sedation is a drug-induced depression of consciousness during which I may respond to verbal commands but will have little or no memory of the procedure.

I have been made aware that the administration of medications for sedation include a risk of complications including rare, but potentially serious reactions to medications, including allergic reactions, excessive lowering of blood pressure, nausea, vomiting, Loss of sensation, loss of limb function, paralysis, organ damage, heart attack ,stroke and loss of life are extremely rare occurrences.

Following the procedure and anesthesia, I agree to the following:

- Until the day after the procedure, I will not drive, use machinery or engage in other activities that require me to be alert.
- I have made arrangements for a responsible adult to drive me home.
- For 24 hours after the procedure, I will not drink any alcoholic beverages or take any medications such as Valium, narcotics or sleep medications, unless approved by my physician. These medications may react with sedation and cause side effects.
- I will report any persistent symptoms to my doctor or his/her staff in accordance with the Discharge instructions provided to me.

By signing this form, I acknowledge that I have read this form, or that it has been read to me, that I fully understand its contents and that I have no questions, and do consent to the administration of anesthesia as deemed appropriate for me.

DATE/TIME

SIGNATURE OF PATIENT OR GUARDIAN

WITNESS

SIGNATURE OF PHYSICIAN