



## CONSENT FOR ANESTHESIA

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

I request and voluntarily give my authorization and consent to the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff at Palisade Surgery Center, LLC.

Dr. \_\_\_\_\_ has explained to me that \_\_\_\_\_ is/are  
(Local/general/Regional  
recommended for the performance of surgical procedure to which I have consented. He/  
she also explained to me that an anesthesiologist at Palisade Surgery Center, LLC. will  
administer the anesthetic. He/she also explained to be the nature and purpose of the  
anesthesia, the route of administration and its effects and possible complications, which  
include but is not limited to the following: allergic reaction, bleeding, blood clots,  
infection, nerve injury, stroke, brain damage, injury to teeth, damage to vocal cords,  
respiration problems, pain, loss of sensation, weakness, paralysis, headache, blindness,  
cardiac arrest, and loss of bodily functions for life. The expected benefits, risks, and the  
alternatives, if any, have been fully explained to me.

I acknowledge and understand that no guarantees or assurances have been made to me concerning the results of the administration of such anesthesia.

Having read this form, talked with my physician or anesthesiologist, my signature below acknowledges that I voluntarily give my authorization and consent to the administration of anesthesia. I attest before the witness whose signature appears below that I understand the nature of the anesthesia, the route of administration, its effects and possible complications associated with anesthesia and consented thereto.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient's Name (PRINT)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Physician Signature