OFFICE ANESTHESIA SERVICES, LLC

Anesthesia Consent Form

I, _____ (name of patient and/or Guardian), have been informed and have discussed with **Grace Lee Dorsch, M.D.** the risks and benefits of the procedure/service: **oral sedation, inhalation and/or intravenous anesthesia.** I understand I do not have to have this procedure/service performed. I have had the opportunity to ask questions and have had them answered in terms I understand.

I understand there are risks to this procedure including but not limited to: nausea and vomiting, bruising at intravenous insertion site, allergic reactions to medications given, recall of events during procedure, nose bleeds, sore throat, breathing problems, blood pressure changes, heart arrhythmias, and even death.

I understand that the medications can have prolonged drowsiness; therefore, I must have a responsible adult drive me home and stay with me until I am able to care for myself. During the recovery time (usually 24 hours), I understand I should not drive, operate complicated machinery, or make important decisions such as signing legal documents.

I understand the importance of having an empty stomach prior to anesthesia administration. I agree I have not had anything to eat or drink for the eight (8) hours prior to anesthetic administration (except for approved medications taken only with a sip of water).

I agree to proceed with the administration of anesthesia and medications.

Signature of patient/guardian: _____
Printed name: _____
Date: _____
Physician Signature: _____
Printed name: Grace Lee Dorsch, M.D.
Date: _____
Witness: _____
Printed name: _____
Date: _____

Patient Name:_____

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