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Summit anesthesia

CONSENT FOR ANESTHESIA SERVICES

The following is provided to inform patients and parents about the risks of treatment under anesthesia. It is not presented to make you more apprehensive but rather to better inform you concerning you or your child's care.

I hereby authorize and request Mitchell Duckworth, DDS, to perform the anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize and request the administration of such anesthetics (local, sedation or general) by any route that is deemed suitable by the dentist anesthesiologist. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia.

It has been explained to me that all types of anesthesia, although safe, involve some risks. I have been informed and understand that occasionally there are complications from anesthetic and therapeutic medications, including but not limited to: pain, bruising, numbness, infection, swelling, bleeding, skin discoloration, nausea, vomiting, allergic reaction, stroke and heart attack. I further understand and accept the risk that complications may require hospitalization and may even result in death. Serious complications may occur, but are extremely rare.

I confirm that the patient has had nothing to **EAT** since _____**DRINK** since _____. Medications, anesthetics and prescription drugs often cause drowsiness and loss of coordination. I have been advised that the patient should not participate in any activities that require gross motor coordination until after full recovery from anesthesia. I have been advised that a responsible adult should be in constant attendance upon returning home until after full recovery from the anesthetic.

I have been fully advised of and completely understand the alternatives to sedation and general anesthesia and accept the possible risks. I acknowledge the receipt of and understand the pre-operative and post-operative instructions. I understand that it is my responsibility to inform the anesthesiologist of all medications, drugs, and herbal products currently used, prior to receiving anesthesia.

I understand that anesthetics, medications and drugs may be harmful to an unborn child. I certify that to my knowledge the patient is not pregnant or trying to become pregnant.

I consent to the anesthesia deemed appropriate by my anesthesiologist. I acknowledge that I have read this form or had it read to me, and that I understand the risks, benefits, alternatives, and the expected result of the proposed treatment.

Patient Name_____

Patient Signature_____

Signature (parent or legal guardian)_____**Date** _____