MIDWEST
SURGERY CENTER
OF KANSAS CITY

Consent for Anesthesia Services

I hereby authorize and request _____ to adminster the anesthesia that has been previously explained to me as well as any additional anesthesia services or procedures that may be considered necessary. I consent to the adminstration of any local, general, or sedation anesthesia by whichever route is deemed appropriate by the dentist and anesthesiologist. I understand that the anesthesiologist is solely responsible for the adminstration, monitoring, and maintenance of the anesthesia throughout the procedure.

It has been explained to me that all forms of anesthesia, while safe, carry inherent risks and the possibility of complications. This includes but is not limited to: pain or discomfort, bruising, swelling, bleeding, numbness, infection, skin coloration, nausea, vomiting, allergic reaction, stroke, heart attack, or other serious medical complications. I understand and accept the risk that in rare circumstances these complications may require hospitalization, result in permanent injury, or be life-threatening.

I confirm that the patient, or myself, has not had anything to EAT since _____ or DRINK since _____. I understand that failure to follow these instructions may increase the risk of serious anesthesia-related complications and may result in cancelling or rescheduling the procedure.

I understand that anesthetics, medications, and prescription drugs may cause drowniness, dizziness, impaired judgment, and lack of coordination for several hours after treatment. It has been explained that the patient must limit all activities and be accompanied home by a responsible adult who will remain with the patient until fully recovered from anesthesia.

I acknowledge that alternatives to sedation and general anesthesia have been explained to me, along with potential risks and benefits. I accept the risks of the chosen treatment and understand the pre-operative and post-operative instructions given to me. I further understand it is my responsibility to provide complete and accurate information to the dentist and anesthesiologist regarding medical history, current medications, allergies, or any changes in health prior to receiving anesthesia.

I understand that certain anesthetics, medications, or drugs may be harmful to an unborn child. I confirm that the patient is not pregnant or trying to become pregnant at this time.

By signing below, I acknowledge that I have read this form or had it read to me and give my informed consent to proceed with the anesthesia.

Patient Name _____ **Date** _____

Patient Signature _____

Signature (Parent or Legal Guardian) _____