SWGA
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Consent for Monitored Anesthesia Care

I, _____ , acknowledge that my physician has explained to me that I will have an endoscopy procedure and that sedation with Monitored Anesthesia Care is recommended. I understand that this will involve anesthesia services by a Certified Registered Nurse Anesthetist (CRNA) or an Anesthesiologist (MD or DO).

Monitored Anesthesia Care (with sedation)
Expected Result: Reduced anxiety and pain, partial or total amnesia which may last 3-4 hours
Technique: Drug injected into bloodstream or by other routes producing a semiconscious state. Medications for sedation may include Propofol and/or other medications deemed appropriate by my anesthesia provider during the course of my procedure.
Risks: Include, but are not limited to, an unconscious state, depressed breathing, injury to teeth, nausea/vomiting, aspiration, corneal abrasion, infection, injury to blood vessels, bleeding, adverse drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.

It has been explained to me that all forms of anesthesia involve some risks and no guarantee or promises can be made concerning the results of my procedure. I am aware that in the event of significant complications from the procedure or anesthesia, I may be transported via ambulance to a hospital for further treatment.

I understand that many factors including, but not limited to, those listed below were considered when determining if Propofol or other anesthetics would be an appropriate choice for me:

- My physical condition
- The type of procedure my physician will be performing
- My own anesthesia preference

I understand the importance of providing my health care providers with my complete medical history, including the need to disclose any medications that I am taking, both prescription and over the counter. I also understand that my use of herbal remedies, alcohol, or any other type of illegal drug may result in serious complications and must be disclosed. I further understand that I must disclose any complications that arose from prior anesthetics.

I hereby consent to monitored anesthesia care with sedation. I authorize the administration of anesthesia by a CRNA, MD, or DO employed or contracted by Southwest Gastroenterology Associates (SWGA) and credentialed to provide anesthesia services at Southwest Endoscopy. I also consent, if necessary and deemed appropriate by my physician and anesthesia provider during the course of my procedure, to an alternate type of anesthesia medication.

I certify and acknowledge that I have read this form or had it read to me. I understand the risks, alternatives, and expected results of the anesthesia services and have had my questions answered to my satisfaction.

Patient or Legal Representative Signature Date / Time

Witness Signature Date / Time

Nurse Anesthetist Signature Date / Time