



# SOUTHWEST ENDOSCOPY

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## Consent for Monitored Anesthesia Care - Propofol

I, \_\_\_\_\_, acknowledge that my physician has explained to me I will have an endoscopy procedure and anesthesia is recommended. My physician has explained the options for sedation/anesthesia to me for this procedure and I have requested Propofol. It has been explained to me, and I understand, that anesthesia services are required for the administration of Propofol. I understand a Certified Registered Nurse Anesthetist (CRNA) will be administering the Propofol and monitoring my response.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia. I acknowledge that I do not have allergies to eggs or soy products and understand that these allergies would prevent me from being an appropriate candidate to receive Propofol. I also verify that I have not had a previous allergic reaction to Propofol.

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

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

It has been explained to me that in the event of significant complications from the procedure or anesthesia, I may be transported via ambulance to a hospital for further treatment.

### Monitored Anesthesia Care (with deep sedation)

Expected result: Reduce anxiety and pain, partial or total amnesia.

Technique: Drug injected into bloodstream, breathed into the lungs, or by other routes producing semiconscious state.

Risks: An unconscious state, depressed breathing, injury to blood vessels, injury to teeth, lips or gums.

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

I understand the importance of providing my health care providers with a 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 should also disclose any complications that arose from past anesthetics.

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 service and have had my questions answered to my satisfaction. I have elected to receive Propofol to be administered by a CRNA as my anesthesia of choice.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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

CRNA Signature \_\_\_\_\_ Date \_\_\_\_\_