C. J. A. S. C.

CENTRAL JERSEY AMBULATORY SURGICAL CENTER

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Patient Name: _____DOB:_____

Performing Physician: _____

CONSENT FOR ANESTHESIA

I consent to the administration of Anesthesia or Sedation, and to the use of such Anesthetics or Sedatives as my physician may deem appropriate. I certify that I have read and fully understand this consent statement which has been preceded by an explanation of the risks, benefits, alternatives, and possible complications by my physician, that the explanations therein referred were made to me by Physician (Name) _____ and are understood by me, and that all blanks or statements requiring insertion or completion were filled in before I signed.

Anesthesia Plan: **MAC > CONSCIOUS SEDATION > GENERAL ANESTHESIA**

NO SEDATION

I hereby certify that the risks and benefits of the proposed procedure/treatment as well as the alternatives, have been explained to me by the patient or to the authorized person/ responsible other.

_____ _____
Signature: PATIENT/AUTHORIZED PERSON DATE

_____ _____
Signature: WITNESS DATE

_____ _____
Signature: ANESTHESIOLOGIST DATE