Michael D. DePriest, M.D.
Cosmetic and Reconstructive Plastic Surgery

Patient Name:_____, _____ _____
Last **First** **M.I.**

CONSENT AND AUTHORIZATION FOR OUTPATIENT ANESTHESIA

1. I am asking to receive anesthesia during my pending surgery. I wish to have anesthesia in order to reduce the pain I would otherwise experience.

2. I understand that regardless of the type of anesthesia I will receive, there are a number of common risks that can occur. Some, but not all of the common risks which I have been informed that can occur are: sore throat, hoarseness, nausea and vomiting, muscle soreness, injury to eye, vein irritation, swelling or bruising at the IV (intravenous) site. I understand that placement of airway devices in the mouth or nose to maintain an open airway during anesthesia may unavoidably cause dental or nasal damage, or laceration of the lips or gums.

3. I understand that medications I am taking may cause complications with anesthesia or surgery and that is my best interest to inform my doctor and anesthesia provider of these medicines including, but not limited to aspirin, cold remedies, diet pills, illegal street drugs (narcotics, PCP, marijuana, cocaine, etc.)

4. I understand that anesthesia, regardless of the type or whether administered in a hospital or office, carries with it serious potential risks and consequence, this includes, but is not limited, changes in blood pressure, cardiac arrest, brain damage, paralysis, adverse drug reactions, or death.

5. I acknowledge that the anesthesia provider has informed me of the types of anesthesia I could receive, the risks/benefits/alternatives of each one, and now I accept that recommendation.

6. I understand that while under an anesthetic, conditions may occur which require modification of this consent and therefore, I authorize modifications of this consent that professional judgment deems necessary.

PATIENT'S NAME _____, _____ _____
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7. I understand that I must not eat or drink anything (even water!) after midnight the day prior to surgery unless directly permitted by the anesthesia provider. TO DO SO MAY BE LIFE THREATENING!

8. I understand that the anesthetic medications may cause prolonged drowsiness, therefore I must be accompanied by a responsible adult to drive me home and stay with me for several hours until I am recovered sufficiently to care for myself. Sometimes the effects of the drug can last 24 hours.

9. I understand that during my time of recovery (usually 24 hours) I should not drive, operate complicated machinery or devices, or make important decisions (signing documents, etc.).

10. I understand that my anesthesia will be given to me by a CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA), or a registered nurse under the supervision of Dr. De Priest.

PATIENT AFFIRMATION: I have read and understand the contents of this document and agree to its provisions and consent to the administration of anesthesia during my surgery. I acknowledge that all my questions have been answered in full to my satisfaction regarding this consent that I know the practice of anesthesiology, medicine, and surgery is not an exact science, and that no one has given me any promises or guarantees about the administration of anesthesia and of its results.

PATIENT'S SIGNATURE_____DATE_____TIME_____

WITNESS'S SIGNATURE_____DATE_____TIME_____

ANESTHESIA PROVIDER_____DATE_____TIME_____