



Garden State
Endoscopy
& Surgery Center

200 Sheffield St. Suite 101
Mountainside, NJ 07092
Tel: 908-241-8900 / Fax: 908-241-8933



Patient Name: _____ DOB: _____

Procedure: _____ Performing MD: _____

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 to were made to me by Physician (name): _____ and are understood by me, and that all blanks or statements requiring insertion or completion were filled or in before I signed.

Anesthesia Plan (*Check what applies*):

- ☐ MODERATE IV SEDATION
- ☐ DEEP IV SEDATION
- ☐ GENERAL ANESTHESIA
- ☐ LOCAL/ TOPICAL ANESTHESIA
- ☐ NO ANESTHESIA
- ☐ CONSCIOUS 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