GARDEN STATE ENDOSCOPY & SURGERY CENTER
200 Sheffield Street, Suite 101, Mountainside, NJ 07092 Phone: 908-241-8900

Patient Name: _____DOB:_____

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/CONSCIOUS IV SEDATION**
- **DEEP IV SEDATION**
- **GENERAL ANESTHESIA**
- **LOCAL/ TOPICAL ANESTHESIA**
- **NO ANESTHESIA**

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