Indiana Office-Based Anesthesia
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CONSENT FOR ANESTHESIA

1. All anesthesia services are associated with some degree of risk. Although complications are uncommon, and unlikely, a broad description of possible complications is presented in this consent. The type of care you receive will depend upon your needs and desires, the judgment of the dentist/dental specialist, and the judgment of the anesthesiologist. **Initials** _____

2. Side effects to intravenous anesthetics may include drowsiness, nausea, and vomiting. Most patients experience some sleepiness for several hours after the completion of their surgery. Coordination and judgment are often impaired. Temporary impairment of memory is sometimes experienced for several minutes to hours following general anesthesia. I understand I should not operate dangerous machinery and/or drive for a minimum of 12, preferably 24 hours, after anesthesia. **Initials** _____

3. Other complications sometimes arise from undergoing anesthesia, including but not limited to pain, hematoma (bruise), numbness, infection, swelling, bleeding, phlebitis, vocal cord dysfunction, and allergic reaction. Also possible, but rare, are stroke, brain damage, seizures, cardiac arrest, and death. **Initials** _____

4. Children should remain under the supervision of responsible adults for three to six hours after dismissal from the office, unless directed otherwise by the anesthesiologist. **Initials** _____

5. I understand that anesthetics may be harmful to an unborn child, and may cause birth defects or spontaneous abortion. Anesthetic drugs may also affect a breast feeding child. I am responsible for informing the anesthesiologist of either suspected or confirmed pregnancy or if I am a nursing mother. **Initials** _____

6. I hereby authorize ☐ Dr. Mark Saxen, ☐ _____ to perform anesthesia as explained to me, or any other related procedure deemed necessary as part of the planned anesthesia. I understand the level of anesthesia will be based upon several factors including, but not limited to, the health status of the patient, age, ongoing medical care, and patient preference. The anesthesiologist indicated above has complete responsibility and authority for the administration of anesthesia, which is independent of the surgery or dentistry being performed. I understand I am responsible for informing the anesthesiologist indicated above of any and all medications, street drugs, and health conditions affecting me or my child. **Initials** _____

7. I have had the opportunity to ask questions about my anesthesia, or my child's anesthesia, and I accept the possible risks and benefits. **Initials** _____

_____ _____
Patient signature/Parent signature Date

_____ _____
Witness signature Date