DHC | Digestive Health Center
Outpatient Endoscopy

# REQUEST FOR ADMINISTRATION OF ANESTHESIA

I understand that it will be necessary to be placed under anesthesia in order to perform the described procedure and I consent to the use of anesthesia as deemed necessary and appropriate by my anesthesiologist and physician. Anesthesia involves risks in addition to the risks of the procedure itself. These risks include but are not limited to, adverse drug reactions, neurologic problems, nerve injury, damage to teeth or dental work, respiratory problems, minor pain and discomfort, damage to veins, headaches, backache or worsening pre-existing disease(s) and death. The purpose, necessity, and risks of anesthesia have been explained to my satisfaction by a physician, and there has been sufficient opportunity to discuss the proposed treatment and associated risks.

I DECLARE AND REPRESENT THAT I HAVE READ THE ABOVE AND UNDERSTAND IT TO BE TRUE.
No guarantee or warranty has been made regarding the result of the anesthetic procedures.

**PATIENT/AUTHORIZED AUTHORITY** _____ **Date**_____ **Time**_____

**WITNESS TO SIGNATURE:** _____

If you receive sedation for your procedure:
- ✓ DO NOT drive or operate machinery today. Plan to spend a few hours resting before resuming your normal routine or activities.
- ✓ DO NOT drink any alcoholic beverages today.
- ✓ AVOID making critical decisions or signing legal documents for 24

hours. The above instructions have been explained to me.
I understand them and I am hereby signing this form prior to receiving sedation.

Patient Signature _____ Date _____Time_____

DHC Rep Signature _____ Name of Driver: _____ Ph #: _____

# ADVANCE DIRECTIVES / LIVING WILL / HEALTH CARE PROXY

I understand that I have the right to make choices regarding life-sustaining treatment (including resuscitative measures). A DHC Representative has explained to me that Advance Directives/Living Will/Healthcare Proxy are not honored at this facility. I understand this policy, and I agree to proceed with the proposed procedure as scheduled. I also understand that if I have an Advance Directive and it is provided to DHC, Nursing Personnel will send it to the hospital in case of a hospital transfer.

[ ] I do have an Advance Directive; However, I am aware that my Advance directive **will not** be honored at Digestive Health Center of Thousand Oaks.
[ ] I **do not** have an Advance Directive/Living Will/Health Care Proxy.
[ ] I wish to have information on how I can obtain an Advance Directive/Living Will/Health Care Proxy.

**PATIENT/ AUTHORIZED AUTHORITY**_____**DATE**_____**TIME**_____

**Post-Procedure Call Information:** Please give us a number where you can be reached for tomorrow's follow-up call.
Print Name: _____Phone#_____

**OFFICE USE ONLY**

Call Date:_____ Time: _ _____ Spoke with _____

Complaints: [ ] None Notes:_____

_____



Patient Label Here