

**RIVERDALE ANESTHETIC MEDICINE  
INFORMED CONSENT FOR CLINICAL ANESTHESIA SERVICES**

I hereby authorize Riverdale Anesthetic Medicine to provide clinical anesthesia to myself.

1. Riverdale Anesthetic Medicine has explained and discussed with me the nature and purpose of the proposed anesthesia. This consists of placing a catheter into my vein and administering medicine. My vital signs will be continually monitored throughout the procedure. (Blood pressure, EKG, oxygen saturation, respiration and ventilation.)
2. I consent to the administration of intravenous anesthesia and the inhalation of oxygen under the direction and/or supervision of Riverdale Anesthetic Medicine.
3. Riverdale Anesthetic Medicine have explained and discussed with me the following issues:
  - a) The pre-procedure, procedure and post-procedure risks of anesthesia include but not limited to: inflammation of the vein, bruising and/or discoloration at the injected site, trismus of the muscles of the face, lack of coordination, drowsiness, fainting, allergic reactions, vomiting, nausea, damage to teeth or oral tissues, necrosis of tissues at injection site, brain damage, paralysis, cardiac arrest and/or death.
  - b) The possible or likely results of intravenous anesthesia are to keep me in a sedate or sleep-like state.
  - c) All feasible alterations to the administration of intravenous anesthesia have been explained to me.
  - d) I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment and/or anesthetic.
  - e) The benefits of clinical anesthesia.
4. I understand that while I am receiving anesthesia, conditions may develop which require modifying or extending this consent. I therefore authorize modifications or extension of this consent that professional judgment indicates necessary under the circumstances.
5. I certify that I have not consumed any solid food since midnight and liquids since 4 hours before the time of the procedure.
6. I certify that I have read and fully understand the above consent statement which I had sufficient time to discuss and that all my questions were answered fully by Riverdale Anesthetic Medicine.
7. I consent knowingly and voluntarily to the administration of intravenous anesthesia as outlined above. At all times during the reading, explanation and execution of this form, I possessed all of my mental faculties and was not under the influence of alcohol and/or medications.
8. Riverdale Anesthetic Medicine will bill my insurance carriers when applicable. I hereby authorize my insurance benefits to be paid directly to Riverdale Anesthetic Medicine.

Patient/Legally authorized Rep.: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

RAM: \_\_\_\_\_

Patient Label

**ADVANCED ENDOSCOPY CENTER**  
5500 Broadway, Suite A  
Bronx, NY 10463  
(P) 718-548-7900 (F) 718-548-8900