LIBERTY ANESTHESIOLOGY ASSOCIATES

PHILADELPHIA, PA

CONSENT FOR PRE-SEDATION AND GENERAL ANESTHESIA

PATIENT NAME: _____ SURGERY DATE_____/_____/_____

The listed patient management, pre-sedation and general anesthesia techniques have been explained to me. Side effects are possible, although they are usually minor and include dry mouth, nausea, thirst, shivering, vomiting, short memory lapse, mild bloody nose or a sore jaw, and in rare circumstances serious illness or death. Local anesthetics may cause numbness, tingling, nausea, or headaches. Alternate techniques, if any, have also been explained to me, as have the advantages and disadvantages of each. I understand that some combination of these techniques may be used for completing the dental treatment.

I understand that patient management techniques, pre-sedation and anesthesia will be used in a safe, efficient manner according to the guidelines set forth by the American Society of Anesthesiologists, and the State Dental Advisory Task Force as indicated in Mental Retardation Bulletin # 99-81-54 issued by the Department of Public Welfare on December 31, 1981.

I understand that Liberty Anesthesiology Associates is an independent corporation providing anesthesia services to Special Smiles, Ltd. I further understand that Special Smiles, Ltd. is a licensed tenant of City Center at Northeastern Hospital and that no services are being provided by Temple University Hospital – Health System Northeastern Campus.

ACKNOWLEDGEMENT

I HEREBY GIVE PERMISSION FOR LIBERTY ANESTHESIOLOGY ASSOCIATES, AN INDEPENDENT CORPORATION PROVIDING SERVICE WITH SPECIAL SMILES, LTD TO ADMINISTER GENERAL ANESTHESIA. I UNDERSTAND THAT UNANTICIPATED CIRCUMSTANCES MAY CALL FOR CHANGES IN THE PLANNED ANESTHETIC. I THEREFORE AGREE TO ANY CHANGE IN THE MANAGEMENT OF ANESTHESIA AS DEEMED NECESSARY BY THE ANESTHESIOLOGIST.

I acknowledge that I have read and understand this consent, and that all questions about patient management, pre-sedation and general anesthesia have been answered in a satisfactory manner. I further understand that this consent form is invalid if altered but that I have the right to be provided with answers to questions, which may arise during the course of treatment.

I certify that I am the legal guardian of the above referenced patient or have otherwise been empowered to give consent on behalf of the patient. This consent shall remain in force for 60 days after date signed or unless otherwise terminated by me.

_____ Date _____/_____/_____

Name of Parent/Guardian (please print full name)

_____ _____

Signature of Parent/Guardian Signature of Witness

_____ _____

Relationship to Patient Name of Witness (please print full name)

_____

Phone Number of Legal Guardian