

## CONSENTIMIENTO DE ANESTESIA Y/O SEDACION

**Complete Name:** JUAN GONZALEZ

**Date of Birth:** 01/09/1971

**I hereby authorize:** -----**Anesthesia**  
**Physician(s)**

**For (ANESTHESIA TECHNIQUE):** -----

1. The physician has explained to me the risks of this procedure, advised me regarding other alternative treatments and has informed me of the possible outcomes and consequences if my condition is not treated. I also understand the anesthesia service is necessary, so the physician can perform the surgery or procedure.
2. I have been explained that each type of anesthesia involves some risks and there are no guarantees regarding the outcome of my treatment or procedure. Although rare, there may be serious and unexpected complications; these include the remote possibility of infection, bleeding, side effects, cloths, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.

I understand those risks apply to any form of anesthesia and that any other additional or specific risk related with the proposed anesthesia has been explained to me.

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In addition, I understand that many factors determine the type of anesthesia to be used, including my physical condition, type of procedure performed by the surgeon, his/her preference, as well as mine.

I have been explained that sometimes, a specific type of anesthesia that involves the use of local anesthetics, with or without sedatives, may not have a good result; therefore, another type of anesthesia may be administered, including general anesthesia.

3. Regardless of the type of anesthesia administered, I understand there are a number of common and predictable risks and consequences. I have been informed that some, but not all common and predictable risks and consequences are: sore throat and hoarseness, nausea and vomiting, pains.  
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4. Also, I understand the use of medical instruments in the mouth to keep the airways open during the administration of the anesthesia may unavoidably cause damage to the teeth, including fracture or loss of teeth, dental bridges, dentures, crowns and fillings, laceration of the lips and gums.
5. I understand the medications I currently take may cause complications with the anesthesia or surgery. I understand that for my own benefit, I need to inform my physicians of any medication I take now, including but not limited to aspirin, cold medications, phencyclidine, marihuana, cocaine, vitamins, minerals and herbal supplements.
6. I have heard the explanation of the physician regarding the type(s) of anesthesia that can be administered, its benefits and common and predictable risks, as well as the alternatives. Now I accept his/her recommendation, with the exception of:  
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(document any allergies or if you deny any)

7. I understand that during the course of the procedure, surgery or treatment, the use of invasive devices for observation may be necessary. The risks/benefits related with this type of monitoring have been explained in detail and understood by me.
8. I understand certain conditions may arise during the administration of the anesthesia that require the change or extension of this consent. Therefore, I authorize the changes or extensions to this consent the anesthesiologist considers necessary according to the circumstances.
9. **I hereby give my consent and authorize blood transfusion / administration or its components/products and medications during the surgery and hospitalization, when considered appropriate by my attending physicians. I understand there are no guarantees regarding blood transfusions, its components products or medications.**
10. I understand I must not eat or drink anything, not even water, after twelve (12) midnight of the day before surgery, unless allowed by the physician.
11. **I understand and agree that the anesthesiologist and the assistant doctors are not employees of CLINICA ESPECIALIZADA DE AZUERO S.A.**
12. I have had the opportunity to make all the questions related with the anesthesia and these have been completely answered to my satisfaction.
13. **I understand the content of this document; I agree with the provisions and give my consent for the administration of anesthesia during the procedure, surgery or treatment I'm about to undergo. I also acknowledge the practice of anesthesia, medicine and surgery is not an exact science and no one has made any guarantees regarding the administration of the anesthesia or its results.**
14. **I have been completely informed and give my consent for the use of conscious sedation. The way in which it is used may cause loss of protective reflexes.**
15. I have read the previous paragraphs and these have been explained to my full satisfaction.

  
Clínica Especializada de Azuero  
CUIDANDO TU SALUD

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Patient's signature

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Signature of Patient's Representative or  
Legal Guardian

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Witness (only of signature)

\_\_\_\_\_  
Physician's signature

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