

CONSENT FOR ANESTHESIA SERVICES

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesic after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the anesthesia/analgesia.*

I have been scheduled for surgery or a procedure. I understand that anesthesia/analgesia are needed so that my doctor can perform the operation or procedure. Analgesia services refer to the pain management care provided shortly before, during, and immediately following the procedure.

ALTHOUGH RARE, SEVER UNEXPECTED COMPLICATIONS CAN OCCUR WITH EACH TYPE OF ANESTHESIA, INCLUDING THE POSSIBILITY OF INFECTION, BLEEDING, DRUG REACTIONS, BLOOD CLOTS, LOSS OF SENSATION, LOSS OF VISION, LOSS OF LIMB FUNCTION, NERVE DAMAGE, BREATHING AND HEART PROBLEMS, PARALYSIS, STROKE, BRAIN DAMAGE, HEART ATTACK OR DEATH. I understand that these risks and hazards apply to ALL forms of anesthesia/analgesia, and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia/analgesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique that involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me. I understand that anesthesia/analgesia involves the risks and hazards as stated in this consent but I request the use of anesthetics/analgesia for the relief and protection from pain during the planned and additional procedures.

<input type="checkbox"/> General Anesthesia	Expected Result	Total unconscious state; possible placement of a tube into the windpipe.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes.
	Risks (include but not limited to)	Nausea, vomiting, mouth or throat pain, hoarseness, injury to vocal cords, teeth, lips, mouth or eyes, memory dysfunction/memory loss, permanent organ damage, brain damage, awareness during the procedure under anesthesia, injury to blood vessels, vomiting, aspiration, pneumonia, headache, shivering.
<input type="checkbox"/> Monitored Anesthesia Care with sedation (Conscious sedation)	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes, producing a semi-conscious state.
	Risks (include but not limited to)	An unconscious state, depressed breathing, injury to blood vessels, permanent organ damage, memory dysfunction/ memory loss, brain damage, nausea, vomiting, mouth or throat pain, hoarseness, injury to mouth or teeth, aspiration, pneumonia, headache, shivering, permanent organ damage, brain damage, potential to convert to a general anesthetic if the sedation is not adequate.

Affix Patient Sticker

I voluntarily request that anesthesia and/or pain management care provided shortly before, during and immediately following the procedure as indicated above to be administered to me (the patient). I understand it will be administered by an anesthesia provider and/or the operating practitioner, and such other health care providers as necessary, including anesthesiologists and/or certified registered nurse anesthetists under the supervision of an anesthesiologist, and/or by the doctor performing and/or participating in the procedure. I also consent to an alternative type of anesthesia and resuscitation, if necessary, as deemed appropriate by the anesthesia provider, the operating practitioner and/or by the doctor performing and/or participating in the procedure.

I understand the importance of providing my health care providers with a complete medical history, including the need to disclose any medications that I am taking, both prescription and over the counter. I also understand that my use of herbal remedies, alcohol, or any type of illegal drug may give rise to serious complications and must also be disclosed. I further understand that I should also disclose any complications that arose from past anesthetics.

I understand that no promises have been made to me as to the result of the anesthesia/analgesia methods.

I have also been given an opportunity to ask questions about my anesthesia/analgesia methods, the procedures to be used, the risks and hazards involved, and alternative forms of anesthesia/ analgesia. I believe that I have sufficient information to give this informed consent.

I acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives, and expected results of the anesthesia/analgesia service and that I had ample time to ask questions and to consider my decisions.

Patient's Signature

Date and Time

Patient's Legal Representative

Date and Time

Relationship to Patient

*Signature of Anesthesia Care Team or
Physician Administering the Anesthesia/Analgesia*

Affix Patient Sticker