## PATIENT CONSENT AND AUTHORIZATION

**Procedure: Anesthesia**

## PROCEDURE DISCLOSURE OF SPECIFIC RISKS AND CONSENT

1. I, the above named patient, am asking to receive anesthesia during my pending procedure / operation / treatment. I want to have anesthesia in order to lessen the pain I would otherwise experience.

2. I understand that medications that I am taking may cause complications with anesthesia or surgery. I have informed my doctors about the nature of any medications I am now taking including but not limited to aspirin, appetite suppressants, cold remedies, narcotics, PCP, marijuana and cocaine.

3. I understand the more serious potential risks and consequences of anesthesia include but are not limited to **changes in blood pressure, memory, infection, drug reactions, cardiac arrest, brain damage, nerve damage, paralysis or death. Other**_____

4. I acknowledge the type(s) of anesthesia recommended for my procedure has / have been explained to me and that in my anesthesiologist's best medical judgment; he/she will provide the appropriate anesthesia necessary to complete my procedure / operation / treatment in the safest possible manner.

5. I understand that during my procedure / operation / treatment invasive monitoring may be deemed necessary to ensure my safety. I agree to indicated monitoring procedures such as arterial line placement, central line placement, or pulmonary artery catheter placement as deemed necessary during the course of said procedure / operation / treatment. I understand the more serious potential risks and consequences of vascular access include but are not limited to: hemorrhage, nerve damage, pneumothorax, stroke, loss of limb.

6. I understand while I am receiving anesthesia, emergency conditions may develop which require modification or extending this consent. I therefore authorize modifications or extensions of this consent that professional judgment indicates to be necessary under the circumstances.

7. I understand that I must not eat or drink anything, not even water, after 12:00 midnight the day prior to my procedure / operation / treatment, unless directly permitted by the anesthesia staff.

8. I consent to the appropriate tests and treatments which may better evaluate my risk and prepare me for surgery as part of my medical care associated with this procedure / operation / treatment.

9. I understand that my anesthesia care will be given to me by or under the supervision of an attending anesthesiologist. I understand that along with my attending anesthesiologist, other personnel such as a Certified Registered Nurse Anesthetist may be involved in my anesthesia care.



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10. I understand that regardless of the type of anesthesia (General, Epidural, Spinal, Regional, Nerve block, or Monitored anesthesia care) and the necessary associated procedures used, there are a number of foreseeable risks and consequences that may occur. The following represent some, but not all, of the common foreseeable risks and consequences that can occur: **sore throat, hoarseness, nausea, vomiting, muscle soreness, injury to eyes, headache or back pain. I understand instrumentation in the mouth to maintain an open airway and ensure my safety during anesthesia might unavoidably result in dental damage including fracture or loss of teeth, bridgework, dentures, crowns, fillings, and laceration of the tongue, gums or lips.**

11. I CERTIFY that I have read and fully understand the above consent for anesthesia, that the explanations therein referred to were made and that all blanks or statements requiring insertion or completion were filled in and that any inapplicable paragraphs or statements, if any, were stricken before I signed this consent.

I ACKNOWLEDGE that no guarantee or assurances have been made to me concerning the administration of anesthesia. The type of anesthesia and alternatives has been explained to my understanding and satisfaction. I have had the opportunity to discuss the anesthesia with the physician(s) concerned and I have received answers to all questions I asked.

_____ _____

Patient / representative signature Date

_____

Time

_____ _____

Witness signature Date

_____ _____

Physician signature obtaining consent Date

Physician signature attests that the risks, benefits and alternative(s) have been explained and that informed consent has been obtained.

If patient is not able to sign for him/her self, the following is to be completed and appropriate signature obtained.

Patient named above is a minor _____ years of age.

Patient named above is unable to sign due to _____