Consent for Anesthesia Services

I, _____ , have been scheduled for surgery, a procedure, or I am requesting anesthesia pain relief for labor and delivery of an infant. I understand that anesthesia services will be needed.

I understand that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment.

RARE, SEVERE, UNEXPECTED COMPLICATIONS CAN OCCUR WITH EACH TYPE OF ANESTHESIA, INCLUDING BUT NOT LIMITED TO THE POSSIBILITY OF INFECTION, BLEEDING, DRUG REACTIONS, BLOOD CLOTS, LOSS OF CIRCULATION, LOSS OF SENSATION, LOSS OF VISION, LOSS OF LIMB FUNCTION, ORGAN FAILURE, PARALYSIS, STROKE, BRAIN DAMAGE, HEART ATTACK OR DEATH.

(See List Below)

I understand that invasive monitoring devices may be placed in my veins, arteries or esophagus to more carefully manage my care during anesthesia and these devices themselves may rarely cause severe complications including but not limited to injury to the areas of the body where they are placed.

I understand that these risks apply to **ALL** forms of anesthesia 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 service that will be used for my procedure and the anesthetic technique to be used are determined by many factors including my physical condition, the type of procedure my doctor is to do, my doctor's preference, as well as my own desire.

I understand 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.

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)	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, vomiting, aspiration, pneumonia
Spinal or Epidural Analgesia/ Anesthesia With sedation Without sedation	Expected Result	Temporary decreased or loss of feeling and/or movement to lower part of the body
	Technique	Drug injected through a needle/Catheter placed either directly into the fluid of the spinal canal or immediately outside the spinal canal
	Risks (include but not limited to)	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, "total spinal"
Major/Minor Nerve Block With sedation Without sedation	Expected Result	Temporary loss of feeling and/or movement of a specific limb or area
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation
	Risks (include but not limited to)	Infections, convulsions, persistent weakness, numbness, residual pain, injury to nerves, blood vessels, collapsed lung, failed block
Intravenous Regional Anesthesia With sedation Without sedation	Expected Result	Temporary loss of feeling and/or movement of a limb
	Technique	Drug injected into veins of arm or leg while using a tourniquet
	Risks (include but not limited to)	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels
Monitored Anesthesia Care (with 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
Monitored Anesthesia Care (without sedation)	Expected Result	Measurement of vital signs, availability of anesthesia provider for further intervention
	Technique	None
	Risks (include but not limited to)	Increased awareness, anxiety and/or discomfort

_____
Patient or Patient's Representative initials

I understand that my surgeon, or doctor ordering the procedure will determine how best to position me during the procedure that will help accomplish my procedure. There may be additional risks of injury associated with the necessary position, including but not limited to loss of vision (blindness), nerve injury, and/or pressure ulcers.

I hereby acknowledge that dental injuries may result from a number of factors, including many that are beyond the control of the anesthesiologist. Such injuries include, but are not limited to, damage to bridgework, dental crowns, caps, fillings, metal or porcelain amalgams and injury or loss of teeth. Pre-existing conditions, the state of my teeth and gums, and uncontrollable physical reflexes that occur during the initial and final stages of anesthesia may contribute to dental injuries during intubation. Although all efforts are taken to prevent dental injury and the risk of dental injury during anesthesia is low, I assume all risks and fully release my anesthesia provider(s) from liability for any injury or damage to my teeth caused by factors that are beyond the control of the anesthesiologist.

I understand the importance of providing my health care providers with a complete and accurate 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 if I am pregnant or if there is any possibility that I may be pregnant, I must inform the anesthesia provider immediately since anesthetics could cause harm to my child or me.

I acknowledge that I have read this form or have had it read or interpreted for me.

_____ _____

Patient's or Patient's Representative Signature *Date and Time*

I consent to anesthesia services and authorize that it be administered by an Anesthesiologist or anesthesia care team, including Certified Registered Nurse Anesthetists, Anesthesiologist Assistants and/or Anesthesiologist Assistant students under the supervision of an Anesthesiologist, all of whom are credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the anesthesia care team.

I have had time to discuss my anesthetic care with the anesthesiologist as signed below. I understand the risks, alternatives and expected results of the anesthesia service. The plan for my anesthesia has been explained to my satisfaction and there has been sufficient opportunity to discuss the appropriate treatment and associated risks. My questions have been answered and I wish to proceed.

_____ _____

Patient's Signature *Date and Time*

_____ _____ _____

Patient's Representative Signature *Relationship to patient* *Date and Time*

_____ _____

Anesthesia Care Team's Signature *Date and Time*