

<p style="text-align: center;">Memorial Hospital</p>	<p style="text-align: center;">DATE</p>	<p style="text-align: center;">IMPRINT WITH PATIENT LABEL</p>
<p style="text-align: center;">CONSENT TO ANESTHESIA</p>		

_____ acknowledge that _____
 has explained to me the Anesthesia options for my surgery and that all forms of Anesthesia involve risks and that no guarantees or promises were made concerning the results of my anesthetic procedure or treatment. Although rare, severe complications with anesthesia can occur. These include adverse drug reactions, loss of sensation or other nerve functions, blood clots, infection and bleeding, limb dysfunction, paralysis, lung or kidney failure, vocal cord paralysis or injury, stroke, brain damage, heart attack and death. I understand that these risks exist with all forms of anesthesia and that additional risks are identified below as they may apply to a specific type of anesthesia. I also understand that all other forms of anesthesia may require the induction of general anesthesia under certain circumstances.

GENERAL ANESTHESIA:

Mouth or throat pain, hoarseness, injury to mouth or teeth, injury to blood vessels, aspiration of stomach contents, pneumonia, irritation of eyes and awareness under anesthesia.

SPINAL / EPIDURAL ANESTHESIA OR ANALGESIA:

Headache, backache, buzzing in the ears, seizures, infection, persistent weakness, numbness, residual pain, injury to vessels, total spinal (high level of anesthesia that may lead to low blood pressure and/or a decreased ability to breath, which may require assisted or controlled ventilation) and failure to achieve desired results.

NERVE BLOCK:

Seizures, weakness, persistent numbness, residual pain, failure to achieve desired result.

I.V. SEDATION:

An unconscious state, depressed breathing, injury to a blood vessel.

PRIMARY TYPE OF SERVICE SELECTED:

- General Spinal / Epidural Nerve Block _____
 Monitored Anesthesia care with sedation Monitored Anesthesia care without sedation

RISK OF POTENTIAL BLOOD LOSS AND TRANSFUSION, IF APPLICABLE:

- Minimal Moderate High
 Provider's Initials if Discussed _____

I certify that a member of the Department of Anesthesia has explained to me the risks and potential complications of anesthesia and available alternative treatments. I certify that I have had an opportunity to ask questions and have made an informed decision to consent to anesthesia.
 I authorize and consent to the provision of anesthesia service(s) by _____
 or other members of the Department of Anesthesiology. I authorize and consent to additional or alternative types of anesthesia and medical care if deemed appropriate and necessary by the anesthesia provider.

Patient Signature _____ Date / Time _____
 Patient's Surrogate Signature _____ Date / Time _____
 Relationship to Patient _____

CONSENT TO ANESTHESIA

PREGNANCY QUESTIONS:

For all women of childbearing capability

L.M.P. _____

Is there any possibility that you may be pregnant? Yes No

It has been explained to me that if I am pregnant, additional risks of anesthesia include but are not limited to: miscarriage, early labor, fetal defects, and mental retardation.

Patient Signature _____ Date / Time _____

Patient's Surrogate Signature _____ Date / Time _____

Relationship to Patient _____

ATTESTATION OF ANESTHESIA PROVIDER:

STANDARD:

I have explained the anesthesia options, risks, potential of complications and available alternative treatments and all questions have been answered.

Signature _____ Date / Time _____

SURROGATE:

I have explained the anesthesia options, risks, potential of complications and available alternative treatments to this patient's guardian or next of kin. All questions have been answered and this surrogate has given informed consent on behalf of the patient.

Signature _____ Date / Time _____

ORAL:

This patient is unable to read and sign the consent form but is competent to give consent. I have explained the anesthesia options, risks, potential of complications, available alternative treatments and answered all questions. The patient has given oral informed consent.

Signature _____ Date / Time _____

Witness _____ Date / Time _____

EMERGENCY:

This is an emergency procedure and informed consent could not be obtained without increasing the risk to this patient.

Signature _____ Date / Time _____