

CONSENT FOR ANESTHESIA SERVICES

I, _____, acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the operation or procedure.

It has been explained to me that **all** forms of anesthesia involve some **risks** and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe *complications* with anesthesia can occur and include the remote possibility of *infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death*. I understand that the type(s) of anesthesia 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 which 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.

<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	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia.
<input type="checkbox"/> Monitored Anesthesia Care with Intravenous 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	An unconscious state, depressed breathing, injury to blood vessels, aspiration, pneumonia.
<input type="checkbox"/> Monitored Anesthesia Care without Sedation	Expected Result	Measurement of vital signs, availability of anesthesia provider for further intervention.
	Technique	None.
	Risks	Increased awareness, anxiety and/or discomfort.

I hereby consent to the anesthesia service checked above and authorize that it be administered by _____ or his/her associates, 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 them. I expressly desire the following considerations be observed (or write "none"):

I certify and 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 service and that I had ample time to ask questions and to consider my decision.

PATIENT IDENTIFICATION

Patient's Signature

Date and Time

Substitute's Signature

Relationship to Patient

Witness

Anesthesiologist's Signature