

PATIENT REQUEST AND CONSENT FOR ANESTHESIA SERVICES
DO NOT SIGN THIS FORM UNTIL YOU FULLY UNDERSTAND ITS CONTENTS

DATE: _____ TIME: _____

I have been scheduled for the following surgical or diagnostic procedure for which anesthesia services are available:

I understand that my attending physician or surgeon has or will explain to me the diagnosis requiring this procedure, its nature and purpose, the material risks involved, the likelihood of success of the procedure, and my prognosis if the procedure is rejected. The Department of Anesthesiology is providing to me certain information associated solely with the anesthesia services attendant to this procedure. I understood the explanation of the type(s) of anesthesia I may receive, and the choices are (check all which apply):

MONITORED ANESTHESIA CARE NERVE BLOCKS EPIDURAL SPINAL AND/OR GENERAL ANESTHESIA

I understand that regardless of the type of anesthesia used there are a number of common foreseeable risks and consequences which may occur. The following are some but not all of the common foreseeable risks and consequences which I have been told can occur: sore throat and hoarseness, nausea and vomiting, muscle soreness, and injury to the eyes. I understand that instrumentation put in the mouth to maintain an open airway during anesthesia might unavoidably result in dental damage including fracture or loss of teeth, bridgework, dentures, crowns and fillings, laceration of the gums, tongue and/or lips. I understand the more serious potential risks and consequences of anesthesia include but are not limited to: INFECTION, ALLERGIC REACTION, SEVERE LOSS OF BLOOD, DISFIGURING SCAR, TEMPORARY OR PERMANENT LOSS OF FUNCTION OF ANY LIMB OR ORGAN SUCH AS, BUT NOT LIMITED TO, HEART, KIDNEYS, LUNGS, LIVER, EYES AND BRAIN, PARALYSIS OR PARTIAL PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, INJURY TO OR MISCARRIAGE OF AN UNBORN CHILD, BRAIN DAMAGE, CARDIAC ARREST OR DEATH. In addition to these risks, anesthesia services may involve the risk of blood transfusion complications (including but not limited to exposure to HIV, hepatitis and other infectious diseases). I understand that during my procedure/operation/treatment invasive monitoring may be necessary. I consent to the placement of such invasive monitoring should this need arise.

I acknowledge and understand that during the course of the procedure and anesthesia services described above, conditions may develop which may reasonably necessitate an extension of the original procedures and anesthesia services or the performance of procedures which are unforeseen or not known to be needed at the time this consent is obtained. I therefore consent to and authorize any of the physicians and clinical employees of the Department of Anesthesiology to make the decisions concerning the performance of and to perform such procedures and anesthesia services as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures and anesthesia services that may be unforeseen or not known to be needed at the time this consent is obtained.

I understand that my anesthesia care will be given to me by or under the direction of an anesthesiologist. I also understand that Northlake Surgical Center is a teaching institution, and that along with my attending anesthesiologist and his/her assistants/designees, other personnel such as certified registered nurse anesthetists, physician assistant anesthetists, technicians, interns, residents and trainees may be involved in my anesthesia care.

I have been given ample opportunity to ask questions and any questions I have asked have been answered or explained in a satisfactory manner. By signing below, I acknowledge I have read or had it read or explained to me. I understand and voluntarily consent to allow the physicians of the Department of Anesthesiology and all medical personnel under the direct supervision and control of said physicians and all other personnel which may otherwise be involved in performing such procedures to perform the procedures and anesthesia services described or otherwise referred to herein. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the outcome of my anesthesia care.

PHYSICIAN: I have explained the risks, benefits and alternatives to the patient/patient's representative.

Signature of Physician

Signature of Patient

Witness (please print)

Signature of Authorized Patient Representative

Relationship to Patient

Reason why the patient cannot or did not sign: _____

Additional materials used, if any, during the informed consent process for this procedure included:

NAME:
ACT#:
DOB: AGE:
DR.:
DOS: SEX: