CONSENT FOR ANESTHESIA SERVICES

I, _____, have been scheduled for _____ surgery.
I 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, SEVERE UNEXPECTED COMPLICATIONS CAN OCCUR WITH EACH TYPE OF ANESTHESIA, INCLUDING THE POSSIBILITY OF INFECTION, BLEEDING, DRUG REACTIONS, COGNITIVE DYSFUNCTION, BLOOD CLOTS, LOSS OF SENSATION, BLINDNESS, LOSS OF VISION, LOSS OF LIMB FUNCTION, PARALYSIS, STROKE, BRAIN DAMAGE, HEART ATTACK OR DEATH.** 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 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 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, airway, esophagus or teeth, awareness under anesthesia, injury to blood vessels, respiratory arrest, cardiac arrest, vomiting, aspiration, pneumonia, corneal abrasion.
☐ 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 ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels and nerves, "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)	Infection, convulsions, weakness, persistent numbness, residual pain requiring additional anesthesia, injury to blood vessels and nerves, 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, discomfort, and/or pain.

I consent to the anesthesia service checked above and authorize that it be administered by [ANESTHESIA GROUP] through an anesthesia care team, including Anesthesia Residents, Certified Registered Nurse Anesthetists and Student Nurse Anesthetists under the supervision of an Anesthesiologist, all of whom are credentialed to provide anesthesia services at this health care facility. I understand that [FACILITY] is a teaching institution and that my anesthesia care team may include medical residents, Emergency Medical Technicians, Paramedics and other individuals in training. In addition to the anesthetic discussed above, I also consent to alternative types of anesthesia, if necessary, as deemed appropriate by the anesthesia care team.

BLOOD TRANSFUSIONS

I understand that there are potential risks from blood transfusions, though rare, and that some of these include transfusion reaction, hepatitis, and AIDS (Acquired Immune Deficiency Syndrome). *Check in appropriate box:*

☐ I give consent to receive blood or blood products as determined by my anesthetist and doctor to be necessary for my well being.

☐ I do not want to receive blood or blood products **under any circumstance including death.**

DO NOT RESUSCITATE (DNR) POLICY: If I have signed a request to not be resuscitated during my hospital stay, I understand that by consenting to anesthesia, I am also consenting to a TEMPORARY SUSPENSION of the **DNR** orders until recovery from the effects of anesthesia is complete [OR A CLARIFIED OR MODIFIED RESUSCITATION DIRECTIVE BASED ON THE PATIENT'S OR LEGAL REPRESENTATIVE'S PREFERENCES].

I 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 decisions.

_____ _____
Patient's Signature *Date and Time*

_____ _____ _____
Anesthesia Provider's Signature *Substitute's Signature* *Relationship to Patient*