



PATIENT PLATE

CONSENT TO THE ADMINISTRATION OF ANESTHESIA

I, _____, have been scheduled for _____ . 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, BLOOD CLOTS, LOSS OF SENSATION, 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.

<input type="checkbox"/> General Anesthesia includes intravenous agents and/or inhaled gases	Expected Result	Total unconscious state, possible placement of a tube into the trachea (windpipe).
	Technique	Drug injected into the bloodstream and/or breathed into the lungs and/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.
<input type="checkbox"/> Spinal or Epidural Analgesia/Anesthesia includes needle injection into spinal canal or epidural space <input type="checkbox"/> With sedation <input type="checkbox"/> Without sedation <input type="checkbox"/> PCEA	Expected Result	Temporary decreased or loss of feeling and/or movement to lower part of the body, variable degrees of awareness.
	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".
<input type="checkbox"/> Major/Minor Nerve Blocks includes needle injections near major or minor nerves <input type="checkbox"/> With sedation <input type="checkbox"/> Without Sedation	Expected Result	Temporary loss of feeling and/or movement of a specific limb or area, variable degrees of awareness.
	Technique	Drug injected near nerves providing loss of sensation to the area of operation
	Risks (include but not limited to)	Infection, convulsions, weakness, persistent numbness, residual pain requiring additional anesthesia, injury to blood vessels, failed block.
<input type="checkbox"/> Intravenous Regional Anesthesia <input type="checkbox"/> With sedation <input type="checkbox"/> Without sedation	Expected Result	Temporary loss of feeling and/or movement of a limb, variable degrees of awareness.
	Technique	Drug injected into veins of arm or leg while using a tourniquet.
	Risks (include but not limited to)	Infection, convulsion, persistent numbness, residual pain, injury to blood vessels.
<input type="checkbox"/> Monitored Anesthesia Care (with sedation) Includes local anesthetics with or without intravenous sedatives	Expected Result	Reduce anxiety and pain, partial or total amnesia, variable degrees of awareness.
	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.
<input type="checkbox"/> Monitored Anesthesia Care (without sedation)	Expected Result	Measurements of vital signs, availability of anesthesia provider for further intervention, awareness, availability of further anesthesia intervention.
	Technique	None
	Risks (include but not limited to)	Anxiety and/or discomfort.

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 give consent for certain blood products. (See Refusal of Blood Products by Jehovah's Witness Form)
- I do not want to receive blood or blood products under any circumstance including the risk of death if no transfusion given. (See Refusal of Blood and Blood Products Form)

DO NOT RESUSCITATE – DNR

If I have signed a request not to be resuscitated in case of cardiac arrest, I understand that by consenting to anesthesia I can also consent to a Temporary Suspension of the DNR (Do not resuscitate) orders until recovery from the effects of anesthesia is complete. I can also maintain the DNR order for the surgery and anesthesia.

- I give consent to Temporary Suspension of the Do Not Resuscitate (DNR) order until recovery from the effects of anesthesia is complete.
- I do NOT consent to Temporary suspension of the Do Not Resuscitate (DNR) order. The Do Not Resuscitate order will be maintained for duration of surgery and anesthesia.

I hereby consent to the anesthesia service checked above and authorize that it be administered by an anesthesia care team, including Certified Registered Nurse Anesthetists (CRNA) 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 them. I understand that students and/or residents may assist in my care as part of their training.

I certify that I have read or have had it read to me and fully understand the above consent which has been preceded by an explanation from a representative of Burlington Anesthesia Associates, P.A. I acknowledge and am satisfied that I have been adequately informed concerning material risks, complications, possible alternatives and expected results if any, including not having anesthesia, and specifically consent to such. I certify and acknowledge that I had ample time to ask questions and to consider my decisions.

Patient's Signature

Date and Time

In the event the above named patient is unable to sign for the following reason(s): (i.e. medical emergency, patient unconscious, incompetent, etc.) _____

_____, the above consent is given on behalf of the patient by:

Relative/Representative

Date and Time

Witness

Date and Time

ATTESTATION STATEMENT: The above-referenced patient has been provided with an explanation of the material risks and likely complications that are or may be associated with this procedure/treatment, benefits, alternatives if any, including the likely outcome of not having the procedure/treatment.

Attending Physician Signature

Date and Time

Person obtaining consent (physician, CRNA)

Date and Time