Commons CLINIC Surgery Center of Long Beach

# Anesthesia Consent

CLARITY ANESTHESIA MEDICAL GROUP, INC. INFORMED CONSENT FOR ANESTHESIA SERVICES

You, in consultation with your surgeon, have decided to undergo a procedure that requires anesthesia. Your anesthesia provider has explained your anesthetic options, medically acceptable alternatives, and the substantial and material risks and benefits of the proposed anesthesia. IT IS IMPORTANT THAT YOU, THE PATIENT, READ THIS CONSENT FORM CAREFULLY (or have it read to you) and that you ask questions about any information that you may not fully understand.

All forms of anesthesia involve some risks. No guarantees or promises can be made that you will not suffer a side effect or complication from your anesthesia. The determination of what type(s) of anesthesia are best for you depend on many factors including your physical condition, the type of procedure you are undergoing and the preferences of you and your surgeon/physician. Rare, unexpected and severe complications can occur with all forms of anesthesia, including infection, drug or allergic reactions, vision loss, blindness, nerve injury with loss of sensation or function, paralysis, stroke, bleeding, blood clots, damage to liver, kidney, lungs, heart attack, brain damage and even death. Common side effects and specific complications of particular types of anesthesia are identified below.

**MAC (MONITORED ANESTHESIA CARE) WITH/WITHOUT SEDATION:** Your anesthesia provider will monitor you and may also provide **sedation** by administering intravenous (injected through a catheter into your bloodstream) and/or inhaled drugs to calm your anxiety and produce a semi-conscious state. Your surgeon may administer medications to produce a loss of sensation to minimize pain/discomfort in the area of surgery. While sedated, you may be aware of your surroundings, may be able to hear and respond to your medical providers and/or may remember some or all of the procedure. Rarely, MAC cannot provide adequate relief or the medications used to sedate you may severely depress (lower) your breathing or slow your heart rate. In that event, your procedure may require general anesthesia as explained below.

**GENERAL ANESTHESIA:** General anesthesia involves the use of intravenous (injected through a catheter into your bloodstream) and/or inhaled medications to achieve a total unconscious state. This may involve the use of a breathing tube, which is inserted through your mouth or nose into the windpipe to ensure proper breathing while you are unconscious.

Common side effects and specific complications of anesthesia include, but are not limited to those identified below. **Risks and common side effects include:**

• Nausea and/or vomiting • Mild to moderate decrease in blood pressure and/or heart rate • Injuries to the mouth, lips and surrounding areas • Aspiration (inhaling stomach contents into the lungs), asthma attacks and pneumonia (lung infection and/or swelling) • Convulsions/Seizures • Swelling, tenderness, bleeding and bruising at the injection site • Infection, swelling or other damage to blood vessels • Soreness of the throat and hoarseness • Nodules, polyps or other damage to the vocal cords or windpipe • Esophageal injury from gastric (stomach) tubes and/or esophageal dilators • Rarely, there can be awareness under anesthesia and dreams under anesthesia may be confused with recall of events

**Teeth and dental prosthetics (such as dental implants, veneers, caps, crowns, and bridges) may become loose, broken, or dislodged, regardless of the care provided by the anesthesia provider. By signing this consent, you are acknowledging that neither your anesthesia providers, the facility, nor the entity employing or engaging the anesthesia providers will be responsible for any dental damage or repair costs.**

**REGIONAL ANESTHESIA WITH/WITHOUT SEDATION:** Regional anesthesia involves one of a number of methods for producing numbness or the temporary loss of feeling/sensation and movement in the limb or part of the body where the procedure or treatment will be performed. You may also be given sedatives, which cause drowsiness or sleep. While sedated, you may be aware of your surroundings, may be able to hear and respond to your medical providers and/or may remember some or all of the procedure. Methods of administration include:

**Nerve Block:** Local anesthesia is injected near the major nerves surrounding the area of surgery.

☐ Interscalene Nerve Block ☐ Adductor Canal Block ☐ Popliteal Nerve Block

☐ Axillary Brachial Plexus Block ☐ Supraclavicular Block ☐ Other

_____

Intravenous Regional: Local anesthesia is injected into a vein in the arm or leg and then retained in the area with a tourniquet.

**Local:** Local anesthesia is injected into and around the area of the surgery.

CLARITY ANESTHESIA MEDICAL GROUP, INC. INFORMED CONSENT FOR ANESTHESIA SERVICES **Spinal:** Local anesthetic is injected directly into the fluid surrounding the spinal cord in the back. **Epidural/Caudal:** Local anesthetic is injected in the back into the epidural space directly outside the spinal canal. A plastic tube (catheter) may be inserted into the epidural space and left in place after the needle is removed. Medications are then injected through the catheter, which may be used after your procedure to control your pain. **Sometimes a regional anesthesia, with or without sedation, may not be completely effective or its effects may gradually diminish, requiring a different technique including general anesthesia**. **In addition to the same risks and side effects discussed above,** other side effects and complications can include:

• Extreme decreases in blood pressure and/or heart rate • Nerve damage resulting in numbness, tingling, and/or paralysis, which may be temporary or permanent or, in the case of eye blocks, blindness is possible. **Rare complications include:** infection of the spine or meningitis, paralysis that may be permanent and include loss of bowel/bladder control, and broken epidural catheter or epidural hematoma (blood clot around spine) requiring emergency surgery of the spine.

In order to minimize the possibility of aspiration, the patient is required not to eat or drink anything for a period of time before the procedure. It is extremely important not to eat or drink anything during this time because aspiration of food or stomach contents can lead to severe pneumonia, respiratory failure, and death.

**I understand that the administration of anesthesia will be supplied by, or under the direction and responsibility of, the anesthesia providers, which may include anesthesiologists, certified registered nurse anesthetists (CRNAs) and anesthesiologist assistants (AAs) and from time to time, other healthcare**

**professionals in training may be involved in my care and treatment.**

**Independent Practitioners:** I understand and agree that the anesthesia providers who furnish services to me are independent practitioners exercising their independent clinical judgement. They **are not employees or representatives (agents)** of the surgery center.

By signing below, I HEREBY CERTIFY that I have read this consent form (or had it read to me,) and that my anesthesia provider has fully explained it to me. I have had the opportunity to ask questions, all of which were answered to my satisfaction. I understand my anesthetic options, alternatives, and the substantial and material risks and benefits of the proposed anesthesia. **I do hereby consent** to the administration of my chosen anesthesia, or changes to the plan as may be considered necessary.

**I attest that I am 18 years of age or older, my judgment is not impaired by any legal or illegal substance, and I am signing this consent of my own free will and have not been forced by any person to consent to this procedure.**

## I consent to the administration of anesthesia as discussed with the anesthesia provider.

Signature of Patient or Authorized Representative _____

Witness to Signature _____

Date/Time _____

Relationship to Patient _____

I certify that I have explained to the patient (parent/Authorized Representative) the anesthesia options and medically acceptable alternatives, the material or substantial risks and benefits (both short and long-term) and have allowed the patient (parent/Authorized Representative) to ask questions.

## INITIAL ALL THOSE THAT APPLY

☐ General

☐ MAC (Monitored Anesthesia Care)

☐ Spinal/Epidural

☐ Regional Anesthesia/Nerve Block

Anesthesia Provider Signature _____

Date/Time _____

## Anesthesia Health Information

To help your doctors and nurses provide the best possible care, please fill out this pre-operative health form. Please answer all questions and fill in all blanks. This information will be reviewed with you prior to surgery.

Operation that is planned (in your own words) _____

Medications you take regularly _____

Medicines to which you are allergic _____

Previous operations (include year) _____

_____

Previous serious illness (include year) _____

Your current weight (lbs.) _____

Your current height _____

Time you last ate or drank anything _____

## Anesthesia Consent and Information Form

| | | | |
|---|---|---|---|
| 1. Have you ever had a problem with anesthesia or surgery? | ☐ Yes | ☐ No | _____ |
| 2. Has any blood relative had a problem with anesthesia? | ☐ Yes | ☐ No | _____ |
| 3. Have you ever smoked? #of packs per day? | ☐ Yes | ☐ No | _____ |
| 4. Do you have a cough or cold? | ☐ Yes | ☐ No | _____ |
| 5. Have you ever had asthma? | ☐ Yes | ☐ No | _____ |
| 6. Have you had bronchitis, pneumonia, or abnormal chest X-ray? | ☐ Yes | ☐ No | _____ |
| 7. Do you get shortness of breath walking up two flights of stairs? | ☐ Yes | ☐ No | _____ |
| 8. Have you any difficulty breathing? | ☐ Yes | ☐ No | _____ |
| 9. Have you ever had high blood pressure? | ☐ Yes | ☐ No | _____ |
| 10. Do you have discomfort or pain in your chest? | ☐ Yes | ☐ No | _____ |
| 11. Have you ever had a heart attack? | ☐ Yes | ☐ No | _____ |
| 12. Have you ever had an irregular heart beat? | ☐ Yes | ☐ No | _____ |
| 13. Have you ever had an abnormal electrocardiogram (ECG)? | ☐ Yes | ☐ No | _____ |
| 14. Have you ever had a heart murmur? | ☐ Yes | ☐ No | _____ |
| 15. Do you drink alcohol? How much? | ☐ Yes | ☐ No | _____ |

16. Have you ever had yellow jaundice or hepatitis? ☐ Yes ☐ No _____

17. Have you had any recent exposure to contagious diseases? ☐ Yes ☐ No _____

18. Have you ever given yourself intravenous drugs? ☐ Yes ☐ No _____

19. Have you had possible exposure to AIDS? ☐ Yes ☐ No _____

20. Have you ever had a stroke? ☐ Yes ☐ No _____

21. Do you have numbness or weakness in an arm or leg? ☐ Yes ☐ No _____

22. Have you ever had epilepsy, seizures, or black-out spells? ☐ Yes ☐ No _____

23. Do you have frequent headaches? ☐ Yes ☐ No _____

24. Do you have back problems? ☐ Yes ☐ No _____

25. Have you ever had kidney disease? ☐ Yes ☐ No _____

26. Do you have diabetes? ☐ Yes ☐ No _____

27. Do you have a goiter or thyroid disease? ☐ Yes ☐ No _____

28. Do you have arthritis? ☐ Yes ☐ No _____

29. Do you have problems opening your mouth/moving your neck? ☐ Yes ☐ No _____

30. Have you ever had broken bones of face, neck, or back? ☐ Yes ☐ No _____

31. Have you ever had glaucoma or other eye problems? ☐ Yes ☐ No _____

32. Have you had an ulcer, hiatal hernia or heartburn? ☐ Yes ☐ No _____

33. Do you have loose teeth, dentures, or caps on your teeth? ☐ Yes ☐ No _____

34. Do you have any bleeding tendencies? ☐ Yes ☐ No _____

35. Could you be pregnant? ☐ Yes ☐ No _____

36. Any other health problems? _____

_____

List subjects (numbers) you wish to discuss with the Anesthesiologist

_____

To the best of my knowledge, the above information is accurate.

Patient's Signature _____

Date _____

Reviewed by Anesthesiologist _____

Date _____