

PARKSIDE SURGERY CENTER INFORMED CONSENT FOR ANESTHESIA

1. I, _____, am asking to receive anesthesia during my pending procedure / operation / treatment. I want to have anesthesia in order to lessen the pain I would otherwise experience.
2. I understand that regardless of the type of anesthesia (General, Epidural, Spinal, Regional, Nerve block, or Monitored anesthesia care) and the necessary associated procedures used, there are a number of foreseeable risks and consequences that may occur. The following represent some, but not all, of the common foreseeable risks and consequences that can occur: **sore throat, hoarseness, nausea, vomiting, muscle soreness, injury to eyes, headache or back pain. Rare but serious risks that may occur include but are not limited to changes in blood pressure, memory or recall of events in the OR, infection, drug reactions, cardiac arrest, (heart attack), stroke, brain damage, nerve damage, paralysis or death. Although utmost care will be taken to avoid dental injury, I understand that instrumentation of the mouth to maintain an open airway may be necessary to ensure my safety during anesthesia and might unavoidably result in dental damage including fracture or loss of teeth, bridgework, dentures, crowns, fillings, and laceration of the tongue, gums or lips.**
I understand that medications that I am taking may cause complications with anesthesia or surgery. I have informed my doctors about the nature of any medications I am now taking including but not limited to aspirin, appetite suppressants, cold remedies, pain medications including narcotics, PCP, marijuana and cocaine.
I acknowledge the type(s) of anesthesia recommended for my procedure has / have been explained to me and that in my anesthesiologist's best medical judgment, he/she will provide the appropriate anesthesia necessary to complete my procedure / operation / treatment in the safest possible manner.
3. I understand that during my procedure / operation / treatment invasive monitoring may be deemed necessary to ensure my safety. I agree to indicated monitoring procedures such as arterial line placement, central line placement, or pulmonary artery catheter placement as deemed necessary during the course of said procedure / operation / treatment.
4. I understand that I must not eat or drink anything, after 12:00 midnight the day prior to my procedure / operation / treatment, unless directly permitted by the anesthesia staff.
5. I understand that my anesthesia care will be given to me by or under the supervision of an attending anesthesiologist. I understand that along with my attending anesthesiologist, other personnel such as a Certified Registered Nurse Anesthetist may be involved in my anesthesia care.
6. I CERTIFY that I have read and fully understand the above consent for anesthesia, that the explanations therein referred to were made and that all blanks or statements requiring insertion or completion were filled in and that any inapplicable paragraphs or statements, if any, were stricken before I signed this consent.

I ACKNOWLEDGE that no guarantee or assurances have been made to me concerning the results of the operation/procedure. I have had the opportunity to discuss the anesthesia with the physician(s) concerned and I have received answers to all questions I asked.

Patient/Representative Signature _____ **Date/Time** _____

Witness Signature _____ Date/Time _____
(Optional)

Physician Signature _____

Physician signature attests that the risks, benefits and alternative have been explained and that informed consent has been obtained.

IF THE PATIENT IS A MINOR OR UNABLE TO SIGN, COMPLETE THE FOLLOWING:

I UNDERSTAND AND ACCEPT ON BEHALF OF THE PATIENT ALL THE ABOVE

Patient is a minor _____ years of age.

Patient named above is unable to sign due to _____