



DISCLOSURE AND CONSENT

ANESTHESIA and/or PERIOPERATIVE PAIN MANAGEMENT (ANALGESIA)

TO THE PATIENT: You have the right to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesia after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the anesthesia/analgesia.

I voluntarily request that anesthesia and/or perioperative pain management care (analgesia) as indicated below be administered to me (the patient). I understand it will be administered by an anesthesia provider and/or the operating practitioner, and such other health care providers as necessary. Perioperative means the period shortly before, during and shortly after the procedure.

I understand that anesthesia/analgesia involves additional risks and hazards but I request the use of anesthetics/analgesia for the relief and protection from pain or anxiety during the planned and additional procedures. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me.

I understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest, brain damage, paralysis, or death.

I also understand that other complications may occur. Those complications include but are not limited to:

Check planned anesthesia/analgesia method(s) and have the patient/other legally responsible person initial:

__ GENERAL ANESTHESIA – injury to vocal cords, teeth, lips, eyes; awareness during the procedure; memory dysfunction/memory loss; permanent organ damage; brain damage.

__ REGIONAL BLOCK ANESTHESIA/ANALGESIA - nerve damage; persistent pain; bleeding/hematoma; infection; medical necessity to convert to general anesthesia; brain damage.

__ SPINAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

__ EPIDURAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

__ DEEP SEDATION - memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

__ MODERATE SEDATION - memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

__ PRENATAL/EARLY CHILDHOOD ANESTHESIA – potential long-term negative effects on memory, behavior and learning with prolonged or repeated exposure to general anesthesia/moderate sedation/deep sedation during pregnancy and in early childhood.

Additional comments/risks: _____



I understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

I have been given an opportunity to ask questions about my anesthesia/analgesia methods, the procedures to be used, the risks and hazards involved, and alternative forms of anesthesia/analgesia. I believe that I have sufficient information to give this informed consent.

This form has been fully explained to me, I have read it or have had it read to me, the blank spaces have been filled in, and I understand its contents.

Patient/Other Legally Authorized Representative (signature required):

Print Name

Signature

Date: _____

Time: _____ A.M./P.M.

WITNESS:

Print Name

Signature

Address (Street or P.O. Box)

City, State, Zip

ANESTHESIA/PROVIDER CERTIFICATION

I hereby certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the proposed anesthesia. I have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/guardian understands what I have explained and has consented to undergo the proposed anesthesia.

Anesthesia/Provider Signature _____ Date _____ Time _____

This form is designed to comply with the requirements promulgated by the Texas Medical Disclosure Panel