HOLY CROSS HOSPITAL

CONSENT FOR ANESTHESIA

I, the undersigned patient or representative acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also 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 that no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include, but not limited to the remote possibility of *infection, bleeding, drug reactions, blood clots, loss of sensation, 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 as they may apply to a specific type of anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure the doctor is to perform, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique, including general anesthesia may be to be employed.

☐ **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	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration or pneumonia.
☐ **Spinal or Epidural Analgesia/Anesthesia**	*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 spinal canal or immediately outside the spinal canal.
	Risks	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.
☐ **Major/Minor Nerve Block** ☐ **Local Anesthesia**	*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	Infection, convulsions, persistent numbness, residual pain injury to blood vessels.
☐ **Intravenous Regional Anesthesia**	*Expected Result*	Temporary loss of feeling and/or movement of limb.
	Technique	Drug injected into veins of arm or leg while using a tourniquet.
	Risks	Infection, convulsions, persistent numbness, residual pain injury to blood vessels.
☐ **Conscious Sedation** ☐ **IV Sedation**	*Expected Result*	Reduced anxiety and pain, partial or total amnesia. (IV sedation usually produces a brief loss of consciousness requiring temporary assisted ventilation).
	Technique	Drug injected into the bloodstream, breathed into the lungs or by other routes.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.

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I, hereby consent to the anesthesia service checked above and authorize that it be administered by an anesthesia provider who is credentialed to provide anesthesia services at Holy Cross Hospital. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the anesthesia provider. I have written below any expressly desired considerations to be observed.

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_____

I certify and acknowledge that I have read this form or have had it read to me, and I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time and opportunity to ask questions and to consider my decision.

_____ _____

Signature of patient or person authorized to sign for patient Date & Time

_____ _____

Witness Date & Time

Patient cannot request or authorize because_____

Relationship to patient_____

_____ _____

Anesthesia Provider Signature Date & Time

(Rev. 4/13)