NORTHEASTERN ANESTHESIA

Consent for Anesthesia Services

I, _____, 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 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 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 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 which 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.

□ General Anesthesia	Expected Result	Total, unconscious state, possible placement of tube in 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, 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 of the spinal canal.
	Risks	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, "total spinal".
□ Major/Minor Nerve Block Nerve Block:_____ Side:_____	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 operation.
	Risks	Infection, convulsions, weakness, persistent numbness, residual pain requiring additional anesthesia, injury to blood vessels, failed block.
□ Intravenous Regional Anesthesia	Expected Result	Temporary loss of feeling and/or movement of a limb.
	Technique	Drug injected into veins or arm or leg while using a tourniquet.
	Risks	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels.
□ Monitored Anesthesia Care	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.

I hereby consent to the anesthesia service checked above and authorize that it be administered by _____ or his/her associates, 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 certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision.
RELEASE OF BENEFITS: I authorize benefits to be paid directly to the physician and the release of any information required in processing the claim.

_____ _____
Patient/Agent/Relative/Guardian* (Signature) Date/Time Print Name Relationship if other than patient

_____
Telephonic Interpreter's ID # Date/Time

OR

_____ _____
Signature: Interpreter Date/Time Print: Interpreter's Name and Relationship to Patient

_____ _____
Witness to signature (Signature) Date/Time Print Witness Name

_____ _____
Anesthesiologist Date/Time Print Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.