St. Charles HEALTH SYSTEM

Patient Label

PATIENT ANESTHESIA INFORMED CONSENT

SIGN ONLY AFTER READING THE WHOLE FORM CAREFULLY AND DISCUSSING YOUR ANESTHESIA PLANS WITH YOUR ANESTHESIA PROVIDER

Name of Patient:_____

Name of Person Signing this Form and Relationship to Patient: _____

_____

Anesthesia Provider:_____, or his or her designee.

Anesthesia Plan:_____

_____

1. The Anesthesia Provider has given me a general description of the type of anesthesia to be used, and has explained to me, in a way I understand, that there may be other possible types of anesthesia, and that there are risks of anesthesia. The Anesthesia Provider has asked me whether I want more detailed explanation, and if I requested it, the Anesthesia Provider has told me in more detail about the type of anesthesia, the available alternatives and the risks.
2. I understand that modern anesthesia is usually safe and most patients do not have many problems with it. However, complications or unexpected symptoms can occur. I understand that anesthesia or sedation may cause side effects, including that I might feel sleepy, dizzy, off balance, or forgetful. I understand that I should not drive a car, operate heavy equipment or power tools, drink alcoholic beverages, or make any important decisions for 24 hours following anesthesia or sedation.

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3. Common problems with general anesthesia may include sore throat, nausea, vomiting, muscle soreness, and injury to teeth or eyes. Though rare, more serious risks include awareness during surgery, severe changes in blood pressure, drug reaction, cardiac arrest, brain damage, blindness, organ system or nerve damage, paralysis and death.
   Common problems with regional anesthesia include soreness or bruising at the injection site, changes in heart rate or blood pressure, spinal headache, and inadequate anesthesia resulting in the need for general anesthesia. Though rare, more serious risks associated with regional anesthesia include bleeding or hematoma at the injection site, nerve damage, paralysis, and death. **Other complications may occur.**
4. I understand that while I am under anesthesia, my condition or other circumstances may require a change to the original anesthesia plan, or a different anesthesia type than is named above. I authorize the Anesthesia Provider to perform any additional or more complicated procedures that, in the Anesthesia Provider's judgment, are necessary for my benefit. I understand that the Anesthesia Provider will follow St. Charles policies and may rely on those people whom I have designated or whom the law designates to make decisions on my behalf.
5. I understand that Advance Directives and Do Not Resuscitate (DNR) orders will not be in effect during my procedure and immediately following my procedure, or, **by initialing here, _____ (initial) I indicate that I have spoken with the Anesthesia Provider about keeping my Advance Directive or DNR order in force. My wishes about my medical care are correct on my Advance Directive or DNR, which I have provided to the Anesthesia Provider.**

ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. NO WARRANTY OR GUARANTEE WAS MADE BY ANY HEALTH CARE PROVIDER AS TO ANY PARTICULAR RESULT OR CURE. I HAVE INFORMED THE ANESTHESIA PROVIDER ABOUT MY SIGNIFICANT MEDICAL CONDITIONS, INCLUDING WHETHER I MAY BE PREGNANT. I HAVE READ THIS WHOLE FORM AND UNDERSTAND AND AGREE WITH ITS CONTENTS. **I GIVE MY PERMISSION AND INFORMED CONSENT TO THE ANESTHESIA DESCRIBED ABOVE.**

*Signature of **Patient** or Authorized Patient Representative **(Required)***	*Relationship*	*Date*	*Time*
Witness** to Signature of Patient or Authorized Patient Representative **(Required)	☐ *Check if telephone consent*	*Date*	*Time*
*Signature of **Anesthesia Provider** obtaining Patient's or Representative's informed consent **(Required)***	☐ *Check if telephone consent*	*Date*	*Time*
Emergency Waiver of Consent. All attempts to reach an authorized surrogate of the patient have been unsuccessful. In my professional judgment, immediate treatment is necessary to preserve life or prevent serious impairment to health.* ***Signature of Anesthesia Provider:*		*Date*	*Time*

* 1 C O N T X *