DISCLOSURE AND CONSENT - ANESTHESIA and/or PERIOPERATIVE PAIN MANAGEMENT (ANALGESIA)

TO THE PATIENT: *You have the right, as a patient, 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 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.

☐____ MONITORED ANESTHESIA CARE (MAC) or SEDATION/ANALGESIA - memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

Additional comments/risks: _____

INITIAL ___ I understand that "Do Not Resuscitate" and "Out-Of-Hospital Do Not Resuscitate" orders will be rescinded while I am under the effects of anesthesia.

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.

DATE: _____ _____ **TIME:** _____ **A.M./P.M.**

PATIENT/OR LEGALLY RESPONSIBLE PERSON SIGN HERE:_____

Witness Name: _____ _____ _____ _____ ___

Address: 1351 W President George Bush Hwy, Richardson, TX 75080

I have explained the risks, benefits, and alterations and patient/family understand(s) and agree(s) to the anesthesia.

Anesthesia Provider/Physician Signature: _____ Date: _____