

FLORIDA PAIN MEDICINE CONSENT TO ANESTHESIA

Patient's Name: _____ Date: _____

1) I hereby authorize; Grace Pitts, RN Christina Helm, RN or Other: _____, associates and such assistants as may be selected by him/her, and the anesthesia provider to administer the anesthetic during my procedure / operation.

2) I understand that I am to receive the anesthesia service below:

CONSCIOUS SEDATION (Level II) is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.	
Expected Results	Reduced anxiety and pain, partial or total amnesia.
Technique	Drug injected into the bloodstream or by other routes producing a semi-conscious state.
Risks	These may include, but are not limited to; swelling, bleeding or discomfort at the site of injection; phlebitis or other damage to blood vessels; nerve damage; allergic reactions to the anesthetic agents; memory dysfunction/memory loss; nausea and vomiting; dental trauma including but not limited to broken/loose teeth; and prolonged recovery from anesthesia. There is also a rare potential for serious harm, including difficulty breathing, permanent organ damage, cardiac arrest and death.

The anesthetic as described above, its risks and alternatives have been explained to my satisfaction. I understand that while use of the above anesthesia is planned, another form of anesthesia may be used if indicated by the unexpected conditions which arise before or during the procedure.

- 3) I understand that I may experience some minor problems as a result of my anesthetic. These may include but are not limited: temporary impairment of judgement, coordination or attention span, nausea or vomiting, headache, sore throat, muscle aches, bruises at the IV sites, injury to teeth, gums or lips, injury to eyes, or injury related to positioning.
- 4) I understand that the frequency of serious complications related to anesthesia depends upon a patient's general health prior to anesthesia and the seriousness of the contemplated procedure. Serious complications are rare in healthy patients undergoing most elective surgeries. It has been explained to me that all forms of anesthesia involve some form of risks and no guarantees or promises can be made concerning the results of my procedure. Although rare, unexpected severe complication can occur with anesthesia and include the remote possibilities of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.
- 5) I understand that the medication that I am taking may cause complications with anesthesia or surgery. I understand that it is necessary to inform my doctor about the nature of any medication or drug I am taking, including aspirin, narcotics, PCP, marijuana and diet drugs such as Phen/Fen.
- 6) I understand if I am pregnant and I refuse a pregnancy test and/or falsely represent the results of a home pregnancy test, I may be increasing my risk of complications from anesthesia (as well as that of my unborn child) including but not limited to spontaneous abortion.
- 7) I understand that a choice of an anesthesia provider exists.

I certify and acknowledge that I have read this form or had it read to me, and have had ample time to ask questions and consider my decision. I understand that risks, alternatives and expected results of the planned anesthetic. I accept the anesthetic risks as described above.

This consent has been translated to me in Spanish. I, the patient, have had the opportunity to ask questions and wish to proceed with the planned procedure. **Pt. Initials: _____**

Translator's Name (Print:): _____

Patient Signature: _____ Date: ___/___/___ Time: _____

Legal Representative Signature: _____ Relationship: _____

Witness: _____

This facility is regulated pursuant to the rules of the Board of Medicine of the State of Florida as set forth in Rule Chapter 64B15 and 64B8 F.A.C.

CRNA/RN/Physician Certification

I do affirm and certify that I have informed the above-named patient, or the patient's representative of the methods of anesthesia and the procedures referred to above and that I have, consistent with my best medical judgement, fully explained the nature and purpose of the anesthetic, the possible alternative anesthesia methods, the risks involved and the possibility of complications in anesthesia method, and after the foregoing information had been explained to the patient or representative who consented to the administration of the anesthetic, but with the understanding that another form of anesthesia may be used if indicated by unexpected conditions arising before or during the procedure.

Signature: _____ Date: ___/___/___ Time: _____
CRNA/RN

Signature: _____
Supervising Surgeon of CRNA/RN