

Informed Consent for Administration of Anesthesia

Please read each item and initial only applicable sections then sign at bottom of the page

____ I understand and accept that there is risk associated any time anesthesia is administered, and though **RARE**, complications may occur and have been discussed with me that include but are not limited to:

Allergic reaction	Aspiration	Hoarseness
Brain Damage	Coma	Blood Clot
Headache	Infection	Muscle Ache
Nausea/Vomiting	Eye Injury	Paralysis
Pneumonia	Positional Nerve Injury	Awareness During Anesthesia
Sore throat	Death	Phlebitis

Vocal Cord Damage

____ I understand that accidental dental injury is also a risk of anesthesia. The nurse anesthetist cannot be held responsible for injuring teeth, partials, or dentures that are already damaged or in poor condition.

____ I certify that I have read, understand, and have fully complied with the pre- anesthesia instructions and intend to fully follow the post-anesthesia instructions.

____ I have informed the nurse anesthetist and/or doctor of all my known allergies.

____ I have informed the nurse anesthetist and/or doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use. I have further been advised which of these medications, if any, I should avoid taking surrounding the procedure date.

____ The nurse anesthetist and doctor have answered all of my questions regarding the anesthesia and procedure.

WOMEN AND TEENS OF CHILDBEARING AGE:

____ By initialing, I attest, to the best of my knowledge, that I am not currently pregnant. If there is any possibility that I may be pregnant, I am advised to have a pregnancy test performed before I undergo anesthesia. I may also choose not to be tested and accept full responsibility for the consequences of my decision. One or more of the anesthesia drugs are known teratogens. Human studies suggest that there is/are specific benzodiazepine-associated teratogenicity and congenital malformations could occur when it is administered at any time during pregnancy. Anesthesia drugs are recommended for use during pregnancy only when there are no alternatives and the benefit outweighs the risk. I understand my anesthetist is relying on my doctor for an opinion that the scheduled procedure today is prudent notwithstanding the risks. I choose to proceed with the procedure under anesthesia, understand and accept the risks, and acknowledge responsibility for the consequences of my decision-making regarding the procedure.

CHILDREN UNDER AGE 3

____ I understand that there is some scientific research supporting a conclusion that administering anesthesia to children under three years of age for more than three hours or on multiple occasions may negatively affect brain development or cause developmental delays. If requested, I may have the relevant FDA Communication provided to me. I understand my anesthetist is relying on my doctor for an opinion that the scheduled procedure today is medically necessary. I, too, agree that the procedure is medically necessary, understand and accept the risks, and acknowledge responsibility for the consequences of my decision-making regarding the procedure.

I have read and understand the risks associated with the administration of anesthesia and agree to proceed

Sign _____ Relationship to patient _____ Date _____

Patient Health History

Patient Name _____ Birthdate _____ Age _____ Gender _____

Weight _____ lbs. Medications Taken Routinely _____

ALLERGIES TO MEDICATIONS _____

Proposed Procedure _____ Doctor _____

Have you every had any complications with anesthesia? Y / N Is there a family History of Problems with anesthesia Y / N

Previous Anesthetics/surgeries _____

Check any of the following **WHICH APPLY** to the patient

PULMONARY(LUNGS) ___ None

- Asthma
- Reactive Airway
- Smoking/Vaping
- Bronchitis/Pneumonia(Last 6 weeks)
- COPD
- Emphysema
- Recent Strep throat infection
- Chronic Cough
- Other _____

ENT ___ None

- Sleep Apnea
- Snoring
- Enlarged Tonsils
- Difficulty Swallowing
- Glasses
- Hearing Aids
- Other _____

CARDIAC(Heart) ___ None

- High Blood Pressure
- Heart Murmur
- Abnormal Heart Tests
- Congenital Heart Disease
- Irregular Heart Beat
- High Cholesterol
- Chest Pain
- Previous Heart Attack
_____ Date
- Pacemaker
- Coronary Artery Disease
- Other: _____

STOMACH LIVER KIDNEYS ___ None

- Acid Reflux/GERD
- Chronic Nausea/Vomiting
- Hiatal Hernia
- Feeding tube
- Hepatitis A,B,or C
- Liver disease(Cirrhosis)
- Kidney Disease
- Kidney Stones
- Peptic Ulcer Disease
- Other _____

NEUROLOGIC(BRAIN) ___ None

- Seizures: Date of Last Seizure _____
- Paralysis/weakness
- CVA/Stroke/TIA: Date _____
- Chronic Headache/Migraine
- Other _____

MUSCULOSKELETAL ___ None

- Cerebral Palsy
- Scoliosis
- Arthritis
- Muscular Dystrophy
- Other _____

ENDOCRINE ___ None

- Diabetes:Date of Last
A1C _____
- Thyroid disorder
- Adrenal Disorder
- Metabolic Disorder
- Other: _____

BLOOD DISORDER ___ None

- Anemia
- Bleeding/Clotting Problems
- Easy Bruising
- Sickle Cell
- HIV/AIDS
- Other: _____

OTHER ___ NONE

- Autism
- Downs Syndrome
- ADD/ADHD
- Depression/Anxiety
- Developmental Delay
- Cancer:Type _____

I have completed this form to the best of my knowledge

Signed _____ Date _____

PRE-OP Evaluation(completed by CRNA)

NPO _____ BP ___ / ___ SpO2 _____ RR _____ HR _____ Temp _____

HEENT _____ Cardiac _____

Pulmonary _____ SLK _____

Neurologic _____ Blood disorder _____

Musculoskeletal _____ Other _____

Endocrine _____

ASA I II III E

Airway I II III IV

Anesthetic Plan ___ IV/IM

___ GA/Intubation

Anesthetic plan, alternatives, risks discussed with parent or legal guardian prior to the start of procedure _____

Signed _____ CRNA Date _____ Time _____