REQUEST FOR ADMINISTRATION OF ANESTHESIA

☐ South Bay Anesthesia Medical Group ☐ Health Care Partners ☐ _____

I authorize the Anesthesia Provider, _____, to provide anesthesia services as part of my surgery. I understand and agree that the primary method of anesthesia administration will be:

☐ General
☐ MAC
☐ Epidural
☐ Regional

This method has been discussed with me in terms that I can understand. If, in the course of treatment, conditions dictate a change in method, I understand and agree that this will be done at the discretion of the Anesthesia Provider in attendance. Additionally, I authorize the performance of any other procedures that in the judgment of the Anesthesia Provider may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the surgery or procedure.

I am satisfied with my understanding of the nature of the anesthesia plan of care and the more common drawbacks and complications associated with it. 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; aspiration; memory dysfunction/memory loss; nausea and vomiting; dental trauma, including fracture or loss of teeth, bridgework, dentures, dental implants, crowns and fillings, and laceration of the gums or lips; and prolonged recovery from anesthesia.

There is also a rare potential for serious harm, including difficulties breathing, permanent organ damage, cardiac arrest and death. I understand that there are risks with anesthesia, and it is impossible for the physician to inform me of every possible complication.

I believe that I have sufficient information to give this informed consent.

No warranty or guarantee has been made as to the outcome of the anesthesia plan of care.

I understand and agree that the anesthesia providers who furnish services to me at the Center are independent contractors with me and not employees of the Center.

I have been given an explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives. I have been given the opportunity to ask questions about the anesthesia.

The undersigned certifies that he/she has read the foregoing; and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

_____ _____
Patient's Signature Date/Time

_____ _____
Patient Representative's Signature / Relationship Date/Time

_____ _____
Witness' Signature Date/Time

Anesthesia Provider Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the anesthesia and have allowed the patient/responsible adult to ask questions.

_____ _____
Anesthesia Provider's Signature Date/Time

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