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 understand that during my procedure my physical condition could change, and my anesthetic may be changed to ensure comfort or my safety. Any necessary changes in my anesthetic will be made with my safety as the first concern.

I understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, aspiration, drug reactions, nerve damage, IV site discomfort and/or swelling, cardiac arrest, brain damage, paralysis, or death.

I also understand that other complications may occur. Those complications include but are not limited to:

GENERAL/DEEP SEDATION ANESTHESIA – Risks include sore throat, hoarseness, injury to teeth, mouth or airway, corneal abrasion (scratch of the eye), aspiration, pneumonia, awareness under anesthesia and muscle aches.

TOTAL INTRAVENOUS ANESTHESIA (TIVA), MONITORED ANESTHESIA CARE (MAC), or CONSCIOUS SEDATION/ANALGESIA – memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

Additional comments:

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 full 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.

_____ _____

Patient or Legal Representative Date/Time

_____ _____

Witness Signature Date/Time

WITNESS ADDRESS:

Medical Center Endoscopy
6560 Fannin, Suite 600
Houston, Texas 77030

PATIENT IDENTIFICATION: <name, date of birth, age, MD name, gender, date, MRN>