PATIENT CONSENT FORM PHYSICIANS ANESTHESIA SERVICE, INC.

Anesthesiology is a specialty of medicine. Your anesthesiologist is a doctor trained to provide you with anesthesia care during the course of medical, surgical, or obstetrical procedures. Your anesthesia care will be provided by one or more anesthesiologists who are members of Physicians Anesthesia Service. This Patient Consent Form is a supplement to the Consent for Surgery or Other Invasive Treatment Form.

The information that follows is a description of the anesthesia or sedation to be used and a listing of the risks that possibly could occur. The information will hopefully enable you to understand your anesthetic procedure and allow you to ask questions of your anesthesiologist. This list is not meant to scare you or discourage you from having your procedure, but rather to inform you that all medical procedures carry risk, and rare events do happen. Such risks and complications may include but are not limited to:

**General Anesthesia:** Nausea, allergic/adverse drug reaction, sore throat, hoarseness, infection, pneumonia, aspiration, nerve injury, eye injury, injury to arteries or veins, awareness under anesthesia, paralysis, stroke, injury to the heart/lungs/brain, and death. Further, I understand instrumentation in the mouth to maintain an open airway during anesthesia might unavoidably result in dental damage including fracture or loss of teeth, bridgework, dentures, crowns and fillings, laceration of the gums or lips, and injury to vocal cords/airway.

**Neuraxial Anesthesia:** (Epidural or Spinal): Backache, headache, blood pressure changes, failure of epidural or spinal to be effective and need for general anesthesia, bleeding, drug reaction, respiratory distress, infection, nerve injury, paralysis, seizures.

**Regional Anesthesia:** Minor pain or discomfort, allergic reaction, failure of the regional block to work, bleeding, infection, nerve injury, injury to arteries or veins, residual numbness or weakness, respiratory distress, seizures, spinal or epidural block, headache, stroke, injury to heart/lungs/brain, death, and need for general anesthesia.

**Transesophageal Echocardiography:** sore throat, injury to lips, teeth, mouth, throat, esophagus, or stomach, hoarseness, difficulty swallowing, painful swallowing, aspiration, and infection.

I understand that receiving anesthesia for any surgery or procedure involves risk, and no promises or guarantees can be made regarding my response to anesthetic agents, other drugs, or procedures associated with my anesthetic care. All procedures may carry unforeseen risks.
I understand that for certain procedures more invasive monitoring may be needed, such as arterial lines, central lines, or transesophageal echocardiography. During my procedure, my physical condition could change, and therefore the type of anesthesia and/or monitoring might need to be changed. Any change in my anesthesia plan would be made with my safety being the first concern of my anesthesiologist.

I certify that I have informed my anesthesiologist and other health care providers of all medications, including prescription, over the counter, alternative remedies and supplements, and any other recreational drug or alcohol use. I also certify that I have informed my doctor of all my known allergies, my medical history, as well as any problems with any of my past anesthetics. UNLESS I have made it explicitly clear to my surgeon and my anesthesiologist that I wish for my DNR order to remain in effect, I understand that by consenting to anesthesia, I am also consenting to a temporary suspension of any “do not resuscitate” orders until I have made a complete recovery from the effects of anesthesia.

I understand that I have been informed of my anesthetic options, as well as the risks and benefits of the various options. I agree with the anesthetic plan, including the method of administration and monitoring that have been discussed with me. I understand that I have had, or will have, the opportunity to ask questions and discuss my anesthetic plan until I am satisfied with the answers and information provided. I understand I may withdraw this consent at any time before the anesthetic is administered.

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Signature of Patient or Authorized Representative  Date  Time

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Printed Name of Patient/Representative  Relationship to Patient

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Printed Name of Anesthesiologist