Brighton Surgery Center, LLC

Acct#:		Age:
DOB:	Sex:	
Dr:		
DOS:		

Westside Anesthesia Associates of Rochester, LLP
CONSENT FOR ANESTHESIA SERVICES

I have been scheduled for a surgical procedure at Brighton Surgery Center.

The procedure will be performed at Brighton Surgery Center, LLC by Dr. ______________________ **DOS:** __________.

I understand that anesthesia services are needed so that my doctor can perform the operation or procedure. It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. **ALTHOUGH RARE, SEVERE UNEXPECTED COMPLICATION CAN OCCUR WITH EACH TYPE OF ANESTHESIA, INCLUDING THE POSSIBILITY OF AWARENESS, INFECTION, BLEEDING, DRUG REACTIONS, BLOOD CLOTS, LOSS OF SENSATION, LOSS OF LIMB FUNCTION, PARALYSIS, STROKE, BRAIN DAMAGE, HEART ATTACK OR DEATH.** I understand that these risks apply to ALL forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique that involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

Type		
☐ General Anesthesia	Expected Result	Total unconscious state, possible placement of a tube into the windpipe.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes.
	Risks (include but not limited to)	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, vomiting, aspiration, pneumonia, post-op airway support.
☐ Spinal or Epidural Analgesia/Anesthesia ☐ With sedation ☐ Without sedation	Expected Result	Temporary decreased or loss of feeling and/or movement to lower part of the body.
	Technique	Drug injected through a needle/catheter placed either directly into the fluid of the spinal canal or immediately outside the spinal canal.
	Risks (include but not limited to)	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, "total spinal", incomplete/failed block-pain and/or pressure.
☐ Major/Minor Nerve Block ☐ With sedation ☐ Without sedation	Expected Result	Temporary loss of feeling and/or movement of a specific limb or area.
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation.
	Risks (include but not limited to)	Infection, convulsions, weakness, persistent numbness, residual pain requiring additional anesthesia, injury to blood vessels, failed block.
☐ Intravenous Regional Anesthesia ☐ With sedation ☐ Without sedation	Expected Result	Temporary loss of feeling and/or movement of a limb.
	Technique	Drug injected into veins of arm or leg while using a tourniquet.
	Risks (include but not limited to)	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels.
☐ Monitored Anesthesia Care (with sedation)	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes, producing a semi-conscious state.
	Risks (include but not limited to)	An unconscious state, depressed breathing, injury to blood vessels, possible conversion to general anesthesia.

I consent to the anesthesia service checked above and authorize that it be administered by Westside Anesthesia Associates of Rochester, LLP, through an anesthesia care team, including Certified Registered Nurse Anesthetists under the supervision of an Anesthesiologist, all of whom are credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the anesthesia care team.

I understand the importance of providing my health care providers with a complete medical history, including the need to disclose any medications that I am taking, both prescription and over the counter. I also understand that my use of herbal remedies, alcohol or any type of illegal drug may give rise to serious complications and must also be disclosed. I further understand that I should also disclose any complications that arose from past anesthetics.

DO NOT RESUSCITATE (DNR) POLICY: If I have signed a request not to be resuscitated in case of cardiac arrest during my surgical center stay, I understand that by consenting to anesthesia, I am also consenting to a TEMPORARY SUSPENSION of the DNR (do not resuscitate) orders until recovery from the effects of anesthesia is complete.

I acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decisions.

______________________ *Anesthesia Care Team's Signature*

______________________ *Patient's Signature*

______________________ *Date*

______________________ *Interpreter (if needed)*

______________________ *Substitute's /Witness Signature*

______________________ *Relationship to Patient*

© 2015, One Medical Passport, Inc.