FOCOS ORTHOPEDIC HOSPITAL

CONSENT FOR ANESTHESIA AND ANALGESIA

Patient Name: ______________________

MR#: ____________________________

I hereby give consent to Dr.(s) ____
and FOCOS Orthopedic Hospital and its staff to administer to ____
(Insert "me" or Patient's name)

the following type of anesthesia:

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(Type of Anesthesia)

to use such anesthetic agents and medications as may be deemed necessary in the course of my/the patient's operation/procedure, and to use such anesthetic procedures and medications as may be required for analgesia (pain relief) after my/the patient's surgicalprocedure.

The nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of the anesthetic agents and/or medications planned or likely be administered, and the alternatives if such anesthetic agents and/or medications are not administered, have been explained to and discussed with me by the physician(s) named above.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the anesthesia may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with anesthesia which can cause adverse consequences not ordinarilyanticipated in advance.

I understand that during anesthesia it is likely that I/the patient will receive intravenous fluids, and that it also may be necessary to insert catheters (small tubes) or other devices to monitor my/the patient's bodily functions. It is possible that an apparatus may be used to assist my/the patient's breathing.

I understand that unanticipated conditions may arise, in which case alternate anesthetic agents or other medications may need to be used. I give consent to the use of such other anesthetic agents or other medications as the physician(s) named above or his/her/their/associates or assistants may deem necessary.

CONTINUED ON REVERSE

I understand that due to unforeseen scheduling or other reasons, the attending anesthesiologist named above may not be available to treat me/the patient. I therefore give permission to the anesthesiologist in charge to choose another attending anesthesiologist to provide anesthesia and analgesia to me/the patient.

I understand that some important anesthesia and analgesia tasks may be performed by practitioners other than the physician(s) named above, and I consent to their doing so. The specific tasks will be determined based on the practitioner's skill set, scope of practice under law, and privileges granted by the hospital, and will be performed under the supervision of the physician(s) named above.
Post graduate physicians (residents and fellows) and qualified medical practitioners who are not physicians (Certified Registered Nurse Anesthetist, or CRNAs) may participate in administering anesthesia and analgesia.

I confirm that I have completely reported to the physician(s) named above my/the patient's history, including the names of any drugs or medication which I am /the patient is currently using or have recently used, any allergies which I /the patient now have (or been thought to have in the past) to any drug or medication, and any dental-related conditions.

I understand that there are risks to me /the patient associated with the use of anesthetic medications, including bruising, infection, hemorrhage, drug reactions, organ reactions, seizure, blood clots, loss of sensation, loss of limb function, paralysis, blindness, brain damage and death. I further understand that there is a possibility of damage to the patient's teeth during anesthesia, particularly if they are weak or decayed, artificial or baby teeth. Depending on the type of anesthetic agent, I understand that I /the patient may experience some discomfort, such as sore throat, hoarseness, headache or residual loss of sensation when the anesthetic wears off. I acknowledge that no guarantees or assurances have been made to me/the patient concerning the expected result of any anesthetic agent or medication.

I confirm that I have read and fully understand this document, and that I have been given the opportunity to ask questions about anesthesia and analgesia and all my questions have been answered satisfactorily, and that I am eligible to give this consent.

Signature of Patient/Parent/Guardian/Healthcare Agent/Other Surrogate: ________________________

________ ________
Date **Time**

Relationship to Patient: ____

Witness Certification: I certify that I witnessed the person whose signature appears above signing this consent for anesthesia and analgesia.

Name of Witness and Signature: ________________________ ________________________
Name **Signature**

________ ________
Date **Time**

Physician Certification: I certify that I have explained to and discussed with the person whose signature appears above the nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of the anesthetic agents and or medications planned or likely to be administered, and the alternatives if such anesthetic agents and/or medications are not administered. I further certify that all parties have signed this Consent for Anesthesia and Analgesia on the date and at the time set forth below.
Signature of Physician: ________________________

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Date **Time**