Figure: 25 TAC §601.9(1)

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 delegated or supervised or personally performed by Dr. _____ and/or physician associates 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 or anxiety during the planned and additional procedures. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me.

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

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

Check planned anesthesia/analgesia method(s) and have the patient/other legally responsible person initial.

☐ _____GENERAL ANESTHESIA – injury to vocal cords, teeth, lips, eyes; awareness during the procedure; memory dysfunction/memory loss; permanent organ damage; brain damage.

☐ _____REGIONAL BLOCK ANESTHESIA/ANALGESIA - nerve damage; persistent pain; bleeding/hematoma; infection; medical necessity to convert to general anesthesia; brain damage.

☐ _____SPINAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ _____EPIDURAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ _____DEEP SEDATION – memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

☐ _____MODERATE SEDATION – memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

Additional comments/risks:

☐ _____PRENATAL/EARLY CHILDHOOD ANESTHESIA - potential long-term negative effects on memory, behavior, and learning with prolonged or repeated exposure to general anesthesia/moderate sedation/deep sedation during pregnancy and in early childhood.

_____

_____

_____

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 fully 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/OTHER LEGALLY RESPONSIBLE PERSON (signature required)

_____

DATE: _____ TIME: _____ A.M. /P.M.

WITNESS:

_____

Signature

_____

Name (Print)

_____

Address (Street or P.O. Box)

_____

City, State, Zip