UNIVERSITY MEDICAL CENTER
Lubbock, Texas

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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 anesthetic/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.

ADMINISTRATION OF ANESTHESIA/ANALGESIA

The plan is for the anesthesia/analgesia to be administered by (Note that the provider listed may change depending on the length of the procedure or other circumstances). I acknowledge that other anesthesia care team members in an anesthesiology residency, medical, Certified Registered Nurse Anesthetist (CRNA), and/or paramedical training program may participate in the care provided to me under the medical oversight of an attending physician at UMC. Non-CRNA nurse sedation is governed by a qualified medical provider. Perioperative means the period shortly before, during and shortly after the procedure.

CHECK THE PLANNED APPROACH AND HAVE THE PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE INITIAL:

(Check one)

_____Physician Anesthesiologist Dr._____ [NAME]
_____Dentist Anesthesiologist Dr._____ [NAME]
_____Non-Anesthesiologist Physician or Dentist Dr. _____ [NAME]

(Check all that apply if the administration of anesthesia/analgesia is being delegated/supervised/medically directed by the above provider)

_____Certified Anesthesiologist Assistant _____ [NAME]
_____Certified Registered Nurse Anesthetist _____ [NAME]
_____Physician in Training _____ [NAME]

The above provider(s) can explain the different roles of the providers and their levels of involvement in administering the anesthesia/analgesia.

Types of Anesthesia/Analgesia Planned and Related Topics

I understand that anesthesia/analgesia involves additional risks and hazards. The chances of these occurring may be different for each patient based on the procedures(s) and the patient's current health. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me.

I (we) 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 (heart stops beating), brain damage, paralysis (inability to move), or death.

I (we) understand that Do Not Resuscitate (DNR), Allow Natural Death (AND) and all resuscitative restrictions are suspended during the perioperative period and until the post anesthesia recovery period is complete. All resuscitative measures will be determined by the anesthesiologist until the patient is officially discharged from the post anesthesia stage of care.

I (we) 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.
LOCATION:_____

☐____ **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.

☐____ **MONITORED ANESTHESIA CARE (MAC) or SEDATION / ANALGESIA**: memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; 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.

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Additional comments/risks:

_____

_____

I (we) understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

I (we) 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.

Anesthesia Risks for Young Children and During the Third Trimester of Pregnancy

I (we) have been informed of the potential adverse effect of anesthesia in young children especially for procedures that may last longer than 3 hours or if multiple procedures are required. I have been informed that the use of general anesthetic and sedation drugs in children younger than 3 years or in pregnant women during their third trimester may affect the development of children's brains.

I have received the FDA Drug Safety Communication bulletin detailing the risks of general anesthesia on brain development in children under the age of 3 years or in third trimester pregnant women.

( ) Yes ( ) Not Applicable

Pregnancy Risks (for women of childbearing age)

It is recommended that elective surgery be delayed until after pregnancy. No one knows the exact risk of birth defects or the possibility of spontaneous abortion from anesthesia. No anesthesia drug or technique can be assured to be safe.

I have read the risks of anesthesia in pregnancy and have been offered a pregnancy test.

Pregnant ( ) Yes ( ) No ( ) Do not know ( ) Not applicable

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.

***DATE**_____**TIME:**_____**A.M. or P.M.**

_____

*PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGN RELATIONSHIP (if other than patient)

_____

*Witness Signature Printed Name

☐ UMC 602 Indiana Avenue, Lubbock, TX 79415 ☐ TTUHSC 3601 4th Street, Lubbock, TX 79430

☐ UMC Health & Wellness Hospital 11011 Slide Road, Lubbock TX

☐ GI & Outpatient Services Center 10206 Quaker Ave, Lubbock TX 79424

☐ OTHER Address:_____

Address (Street or P.O. Box) City, State, Zip Code

Interpretation/ODI (On Demand Interpreting) ☐ Yes ☐ No_____

Date/Time (if used)

Alternative forms of communication used ☐ Yes ☐ No_____

Printed name of interpreter Date/Time

Date procedure is being performed: _____

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Date _____

Resident and Nurse Consent/Orders Checklist

Instructions for form completion: Note: Enter "not applicable" or "none" in spaces as appropriate. Consent may not contain blanks.

Section 1: Enter name of physician(s) responsible for anesthesia/analgesia.

Section 5: Check planned anesthesia/analgesia method(s) and have the patient/other legally responsible person initial. Enter additional risks/comments as discussed with patient.

A. Risks for procedures on List A must be included. Other risks may be added by the Physician.

B. Procedures on List B or not addressed by the Texas Medical Disclosure panel do not require that specific risks be discussed with the patient. For these procedures, risks may be enumerated or the phrase: As discussed with patient" entered.

Date/Time: Enter date and time patient signed consent.

Witness: Enter signature, printed name and address of competent adult who witnessed the patient or authorized person's signature.

If the patient does **not** consent to a specific provision of the consent, the consent should be rewritten to reflect the procedure that the patient (authorized person) is consenting to have performed.

For additional information on informed consent policies, refer to policy SPP PC-17.

Consent

☐	Name of provider	☐	Check planned anesthesia method
☐	No blanks left on consent	☐	No medical abbreviations

Orders

☐	Procedure Date	☐	Procedure
☐	Diagnosis	☐	Signed by Physician & Name stamped

Nurse_____ Resident_____ Department _____

THIS FORM IS NOT PART OF THE MEDICAL RECORD