

Greater Connecticut Anesthesia Associates

INFORMED CONSENT FOR ANESTHESIA SERVICES

Patient Name: _____ **Date of Birth:** _____

I have a general understanding of the procedure to be performed by my physician. I understand anesthesia services are requested or needed for the procedure. I consent to the administration of anesthesia as required for the procedure. I understand and acknowledge that all forms of anesthesia involve some risks and side effects, and the anesthesia provider can make no guarantees or promises concerning the results or outcome of the anesthesia plan of care. I acknowledge that impairment of full mental alertness may persist for several hours following the administration of anesthesia, and will avoid making decisions or taking on activities, which depend on full concentration or judgment during this period.

It has been explained to me all forms of anesthesia have some risks and side effects. Although rare, unexpected severe complications can occur. Possible anesthetic complications include but are not limited to, infection, bleeding, drug interactions, allergic reactions, dental damage, stroke, brain damage, memory dysfunction, memory loss, heart attack, injury to vocal cords, cardiac arrest or death. Complications may require hospitalization. I understand that these risks apply to all forms of anesthesia; additional or specific risks are identified below as they apply to each type of anesthesia.

I understand the section below details the types of anesthesia to be used for my procedure. I understand the anesthetic technique is determined by many factors, including my physical condition, the procedure performed, the physician preference, anesthesia provider care of plan, or my own desires. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the anesthesia provider and physician.

- General Anesthesia:** a controlled, drug-induced state of unconsciousness, accompanied by partial or complete loss of protective reflexes including an inability to independently maintain an airway and/or respond purposefully to physical stimulation or verbal command. May require a placement of a breathing tube in the windpipe or another breathing device. Risks include, but limited to, mouth or throat pain, hoarseness, injury to mouth or teeth, awareness of intraoperative events, injury to blood vessels, aspiration, and pneumonia.
- Deep Sedation:** a controlled, drug-induced state of depressed consciousness from which the patient is not easily aroused, which may be accompanied by partial loss of protective reflexes, including the ability to maintain an open airway independently and/or respond purposefully to physical stimulation or verbal commands. Risks include, but not limited to, infection, mouth or throat pain, hoarseness, injury to mouth or teeth, aspiration, dizziness, nausea, or vomiting can occur.
- Conscious Sedation:** a combination of medicines that help you relax (a sedative) and block pain (an anesthetic) during a medical procedure. It is characterized by a minimally depressed consciousness such that the patient is able to continuously and independently maintain a patent airway, retain protective reflexes, and remain responsive to verbal commands and physical stimulation. Risks include, but not limited to, infection, mouth or throat pain, hoarseness, injury to mouth or teeth, aspiration, dizziness, nausea, or vomiting can occur.

I understand the possible risk and complications of the planned anesthesia care as they have been explained to me. I have had the opportunity to ask questions, and I understand what has been explained. I hereby consent to anesthetic(s) above and authorized the credentialed anesthesia providers of this facility to provide the outlined anesthesia plan. I further understand and certify for my own safety; I have a responsible adult to take me home after my procedure.

Patient Signature/Legal Guardian

Relationship

Date and Time:

Signature of Anesthesiologist/Anesthetist

Date/Time

Witness

Date/Time