CSA SURGICAL CENTER

Consent for Anesthesia Services

I acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also 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, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, and loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all types 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 which 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.

☐ General Anesthesia	Expected	Total unconscious state, possible placement of tube into the windpipe
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes
	Risks	Mouth or throat pain, hoarseness, injury to the mouth or teeth, awareness under anesthesia, injury to the blood vessels, aspiration, pneumonia
☐ Spinal Or Epidural Anesthesia [ ]With Sedation [ ]Without Sedation	Expected	Temporary decreased or loss of feeling and/or movement to lower part of the body
	Technique	Drug injection through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal
	Risks	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, “total spinal.”

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☐ Major/Minor Nerve Block [ ]With Sedation [ ]Without Sedation	Expected	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 operation
	Risks	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels
☐ Intravenous Regional Anesthesia With Sedation	Expected	Temporary loss of feeling and/or movement of limb
	Technique	Drug injected into veins of arm or leg while using a tourniquet
	Risks	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels
☐ Monitored Anesthesia Care With Sedation	Expected	Reduce 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	An unconscious state, depressed breathing, injury to blood vessels
☐ Monitored Anesthesia Care Without Sedation	Expected	Measurement of vital signs, availability of anesthesia provider for further intervention
	Technique	None
	Risks	Increased awareness, anxiety and/or discomfort

I hereby consent to the anesthesia service checked above and authorize that it be administered by Mid Missouri Anesthesia Consultants and/or his/her associates, 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 them.

I certify and 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 decision.

Signature of Patient:_____

Signature of Witness:_____

Date/Time of Signatures:_____