

Figure: 25 TAC §604.5(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 1) the recommended anesthesia/analgesia to be used and 2) the risks related to anesthesia/analgesia. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive anesthesia/analgesia in the perioperative period (meaning shortly before, during and shortly after a procedure). Please ask your physician/health care provider any remaining questions you might have before signing this form.

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):

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 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 procedure(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 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 also understand that other risks or complications may occur depending on the type of anesthesia/analgesia. The type of anesthesia/analgesia planned for me and the related risks for that type of anesthesia/analgesia include but are not limited to:

Check planned anesthesia/analgesia method(s) and have the patient/legally authorized representative 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.

_____ 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:

Check if applicable and have the patient/legally authorized representative initial.

_____ 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.

Granting of Consent for Anesthesia/Analgesia

In signing below, I consent to the anesthesia/analgesia described above. I acknowledge the following:

- I have been given an opportunity to ask questions I may have about:
 1. Alternative forms of anesthesia/analgesia,

2. Steps that will occur during administration of anesthesia/analgesia, and
 3. Risks and hazards involved in the anesthesia/analgesia.
- I believe I have enough information to give this informed consent.
 - I certify this form has been fully explained to me and the blank spaces have been filled in.
 - I have read the form or had it read to me.
 - I understand the information on this form.

If any of those statements are not true for you, please talk to your physician/health care provider before continuing.

Patient/Other Legally Authorized Representative (signature required):

Print Name

Signature

If Legally Authorized Representative, list relationship to Patient:

Date: _____ Time: _____ A.M./P.M.

Witness:

Print Name

Signature

Address (Street or P.O. Box)

City, State, Zip Code