Eastside Surgery Center
1301 4th Avenue NW, Suite 201, Issaquah, WA 98027

Consent for Anesthesia

1. I request and authorize the staff of Advanced Anesthesia Services and such Certified Registered Nurse Anesthetists (CRNAs) as may be assigned by and under the direction of the group to administer anesthesia to me.
2. I understand that my anesthesia alternatives include general anesthesia, regional anesthesia, and monitored anesthesia care with medication as may be considered necessary and/or advisable for my care.
3. I understand that in preparation for, during, or following any medical or surgical procedure(s), conditions may be revealed that necessitate a change in or an extension of the originally planned anesthetic or approach including procedures for invasive monitoring. I request and consent to such additional procedures as my physician(s) and their designees, in the exercise of his/her (their) reasonable professional judgment, deem necessary and/or advisable.
4. I understand that the administration of any anesthetic always involves common risks and consequences including but not limited to sore throat, hoarseness, nausea, vomiting, muscle soreness, injury to the eyes, and injury to blood vessels, headache and backache; lacerations or trauma to lips, gums, tongue, and uvula. Less common to rare risks and consequences include dental damage including fracture or loss of teeth, bridgework, dentures, crowns, and fillings; severe allergic reactions; damage to the vocal cords or voice box; damage to the jaw or temporal mandibular dysfunction (TMJ); awareness under anesthesia; convulsions; infection; severe loss of blood requiring blood and blood component transfusions; cardiac or respiratory arrest; nerve or brain damage and paralysis; aspiration; need for tracheostomy; low flow state ending in blindness and end-organ damage; fire and thermal injury; death or coma.
5. The expected benefit of anesthesia is the control of physical sensation, maintenance of vital body functions during surgery or a procedure, and assistance of my body to tolerate surgery and/or invasive procedures. These benefits are achieved in the vast majority of cases.
6. I understand that the administration of anesthesia is not an exact science, and no guarantees, assurances, or promises have been made or can be made concerning the administration of the anesthesia or its results.
7. I understand that ***I should not drive a motor vehicle***, operate machinery, drink alcohol, take un-prescribed drugs, enter into contractual relationships, or make significant decisions for at least 24 hours following anesthesia.
8. I acknowledge that I have had the opportunity to discuss the anesthetic plan and consent form with the surgeon and anesthesia staff, have given a complete and accurate history to them, and consent to the use of anesthesia. I have my questions answered and believe I have adequate information to give this consent.

X ______________________________ ______________________________

Patient or Representative Signature Date and Time

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Representative Printed Name

If signed by other than patient, indicate relationship: ______________________________

(Parent, Legal Guardian, etc.)

______________________________ ______________________________

Center Representative Signature Date and Time

Anesthetist Declaration: I have reviewed the contents of this document with the patient and witnessed their signature. Unless the patient has declined information as documented above, I have described the care, its possible risks and benefits, alternatives with their risks, and the likelihood of achieving care goals. To the best of my knowledge, the patient or their representative has been adequately informed, understands the information and has consented to the care.

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Signature of Anesthesia Provider Date and Time