SOUTHWEST SURGICAL CENTER

My Request and Consent to Surgery

Proposed Surgery:

I consent to the surgical procedure(s) listed above that are to be performed under the direction of Dr. _____ and whomever he/she shall designate as his/her associates or assistants, and employees of the Southwest Surgical Center.

I further consent to the performance of additional operations or procedures as are considered necessary or desirable, in the judgment of the surgeon/physician, during the surgical procedure stated above.

I understand that it is my responsibility to inform my physician about my allergies, medical history, and history of drug and alcohol use.

The type of surgery and the reason for the surgery have been explained to me. The availability of other forms of treatment and the likely results of other available treatments (including the option of no treatment) have been explained to me. The likely results if the proposed surgical procedure is not done have also been explained to me. I understand that the practice of medicine is not perfect and may at times be not predictable. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from the surgical procedure.

The possible benefits, risks, and complications of the proposed surgical procedure and the alternative treatment methods have been fully explained to my satisfaction. The physicians and employees of the Southwest Surgical Center have encouraged me to ask questions. I have been told of the common risks, complications including, but not limited to, bleeding or infection. The most serious complications, though rare, are losses of one or more body functions and death.

I consent to the disposal by Southwest Surgical Center employees of any implants and/or tissues or parts, which may be removed during the surgical procedure.

For the purpose of advancing medical knowledge: (1) I consent to the presence of other physicians, medical personnel, employees receiving training, and students in the room during my surgical procedure. (2) I consent to the taking and publishing of pictures, video, and electronic/ digital media of the surgical procedure provided my identity is not revealed. (3) I consent to the presence of manufacturer's representatives in the room by invitation of my surgeon to observe the use of products/equipment.

I will not drive home or use public transportation. Someone will take me home.

I realize that my full mental alertness may be impaired for several hours after surgery. I agree to avoid any decision or activity that requires clear thought, judgment, or coordination.

I understand that admission to the hospital may be necessary after the surgical procedure.

The Southwest Surgical Center, in its goal to provide you with a high quality, personally satisfying experience, has partnered with several physicians. This partnership enables us to maintain the Southwest Surgical Center's commitment to innovative, quality care. In the interest of providing our patients with all necessary information for informed decision-making, this notice is to inform you that your physician may have an investment interest in the Southwest Surgical Center. By signing this consent for surgery, you are acknowledging that you have been informed of this fact and that you nevertheless wish to receive services from the physicians providing care at the Southwest Surgical Center in light of this information.

☐ **For patients receiving sedation without an anesthesia care provider**

I understand that sedation refers to the administration of medications to reduce the discomfort of my procedure. I consent to receive sedative medications by or under the direction of ***Dr.*** _____ or his/her designee. I understand that it may be necessary to change to another type of medication or anesthesia technique during my surgery. If deemed necessary by my surgeon/physician, an anesthesia team may participate in the procedure and provide anesthesia/medications. The Anesthesia Team consists of a physician Anesthesiologist and a Certified Registered Nurse Anesthetist (CRNA).

Additional Comments: _____

_____

My consent below means:

1. **I understand what will be done during the surgery and/or anesthesia.**
2. **I am aware of the reasons for the surgery and have been informed of the possible risks and complications.**
3. **I have been informed of the possible alternatives to the surgery.**
4. **I have read and agree to the above and hereby consent to the surgery.**
5. **I have stricken inappropriate lines and/or paragraphs, if any exist, before I signed.**

If you do not understand the above, *do not sign* this form.

Patient's Signature _____

Date _____ Time _____

Authorized Representative's Signature _____

Relationship to Patient _____

Witness Signature _____

Date _____ Time _____

SOUTHWEST SURGICAL CENTER

My Request and Consent to Receive Anesthetics and Anesthesia

Proposed Surgery or Invasive Procedure:

I understand that at the Southwest Surgical Center, every patient who consnts to anesthesia will have the benefit of a physician trained in the medical specialty of anesthesiology that will administer and/or directly supervise my anesthesia care.

I understand it is my responsibility to tell the Anesthesiologist and/or the Certified Registered Nurse Anesthetist (CRNA) about my known allergies, medication history, health history, and history of drug or alcohol use.

I understand an anesthetic is a medicine given to a patient to reduce and/or avoid pain.

I also understand that it may become necessary to progress from local and/or regional to a general anesthetic as determined by my Anesthesiologist. I agree to receive anesthetic/sedative medications as deemed necessary.

☐ **General Anesthesia/ Monitored Anesthesia Care (MAC)**

I understand that with the administration of anesthesia there are risks that include, but are not necessarily limited to, the following: headache, nausea, vomiting, sore throat, muscle aches, damage to teeth, injury to eyes, irritation to blood vessels, nerve damage, breathing problems, severe infection or allergic reactions, including the possibility of exposure to infections from transfusions (i.e. hepatitis, AIDS), cardiac arrest, and death.

☐ **Epidural / "Spinal" Anesthesia**

An epidural is a small flexible catheter that is placed through a needle in the back into the epidural space. The epidural space is located just outside the sac that holds the spinal fluid. Local anesthetic and/or narcotic analgesic medicines are placed through the epidural catheter.

Medicine may also be placed directly through a needle into the sac that holds the spinal fluid. When medicines are placed in this sac it is termed a spinal anesthetic. This is a single dose of medicine that usually lessens pain for 2-4 hours.

Risks of Epidurals and Spinal Anesthesia:
Reaction to the medicines - allergy, itching, nausea, drop in blood pressure, seizures, death.
Spinal Headache. This may require a procedure similar to the epidural to treat the headache, bedrest, intravenous (IV) fluids, or all of the above.
Nerve injury - temporary or permanent tingling, pain, weakness, or very rarely, paralysis.
Bleeding
Infection - would require antibiotics; may result in permanent neurological impairment and/or require surgical correction.
Failure of the epidural or spinal to provide anticipated pain relief.
Back pain.

Fortunately, serious complications of epidurals and spinals (seizures, paralysis, infection, bleeding, nerve injury, and death) are very rare. The less serious risks (drop in blood pressure, spinal headache, failure of the epidural or spinal to relieve pain) are more common.

☐ **Nerve Block Anesthesia**

"Nerve blocks" use local anesthetics to anesthetize a region of the body for surgery.

Risks of nerve block anesthesia:
Incomplete anesthesia - may require a general anesthetic.
Seizures.
Bleeding.
Permanent or temporary nerve injury (that is, pain, numbness, weakness). This may be secondary to a nerve block or the surgery itself.
Infection.
Cardiac arrest and death (fortunately, very rare).
Pneumothorax (collapsed lung), irregular heartbeat, breathing difficulty.

If applicable, my physician and I have reviewed the Do Not Resuscitate (DNR) Order and have determined an appropriate plan of care.

I understand that the practice of anesthesia is not an exact science. I acknowledge that no guarantee or assurance has been made as to the results of my anesthesia care.

The possible benefits, risks, and complications of the proposed anesthesia and the alternative methods have been fully explained to my satisfaction. The physicians and employees of the Southwest Surgical Center have encouraged me to ask questions.

I understand what it means and give my consent to receive anesthesia as explained to me by the Anesthesiologist

Additional Comments: _____

_____

My consent below means:
1. **I understand what will be done during anesthesia.**
2. **I am aware of the reasons for the anesthesia plan and have been informed of the possible risks and complications.**
3. **I have been informed of the possible alternatives to the anesthesia plan.**
4. **I have read and agree to the above and hereby consent to the anesthesia plan.**

If you do not understand the above, <u>do not sign</u> this form.

Patient's Signature _____

Date _____ Time _____

Authorized Representative's Signature _____

Relationship to Patient _____

Witness Signature _____

Date _____ Time _____