1. I, _____ (, or

_____ ☐ Parent ☐ Guardian ☐ Representative (check one)

acting on his/her behalf), am asking to receive anesthesia during my procedure/operation/treatment. I want to have anesthesia in order to lessen the pain I would otherwise experience.

2. I understand that regardless of the type of anesthesia used there are a number of common risks and consequences which may occur. The following are some but not all of the common foreseeable risks and consequences which I have been told can occur: sore throat and hoarseness, nausea and vomiting, muscle soreness, injury to the eyes. Further, I understand instrumentation in the mouth to maintain an open airway during anesthesia might unavoidably result in dental damage including fracture or loss of teeth, bridge work, dentures, crowns and fillings, lacerations of gums or lips.

3. I understand that medications that I am taking may cause complications with anesthesia or surgery. I understand that it is in my best interest to inform my doctors about the nature of any medications I am taking including but not limited to aspirin or aspirin-like anti-inflammatory drugs, cold remedies, narcotics, PCP, marijuana, and cocaine.

4. I understand the more serious potential risks and consequences of anesthesia include but are not limited to changes in blood pressure, drug reactions, cardiac arrest, brain damage, paralysis, or death.

5. I acknowledge that Dr. _____ has told me that in his/her medical judgement the type(s) of anesthesia I could receive is/are (check all which apply):

☐ General Anesthesia ☐ Spinal Anesthesia ☐ MAC (Monitored Anesthesia Care) ☐ Epidural Anesthesia ☐ Other regional anesthetic.
I have listened to the doctor's explanation of the type(s) of anesthesia I may receive, its benefits and common foreseeable risks and consequences as well as those of its alternatives and now accept his/her recommendation with the exception of (check one):
☐ type of anesthesia: _____ ☐ No exception to anesthesia.

6. I understand that during my procedure/operation/treatment invasive monitoring may be necessary. I understand the risks and benefits associated with this type of monitoring which have been fully explained to me.

7. I understand that while I am receiving anesthesia, conditions may develop which require modifying or extending this consent. I therefore authorize modifications or extension of this consent that professional judgement indicates to be necessary under the circumstances.

8. If it is anticipated that I may require transfusion of blood or blood products during my procedure, I will be required to sign a separate INFORMED CONSENT TO BLOOD TRANSFUSION AND/OR BLOOD COMPONENT ADMINISTRATION form. It in the event of an unanticipated emergency during my operative care and, based on the medical judgement of my physician, I require the transfusion of blood or blood products, I understand they will be administered and agree to such action being taken.

9. I understand that I must not eat or drink anything, not even water, after 12 midnight the day prior to surgery unless directly permitted by the anesthesia staff.

10. I consent to appropriate tests and treatments which may better evaluate my risk and prepare me for surgery as part of my medical care associated with this procedure/operation/treatment.

11. I understand that my anesthesia care will be given to me by or under supervision of a George Washington University Hospital attending anesthesiologist. Knowing that the George Washington University Hospital is a teaching institution, I understand that along with my attending anesthesiologist and his/her assistants and designees, other hospital personnel such as technicians, interns, residents and trainees may be involved in my anesthesia care.

12. I understand the Hospital's teaching mission and agree to the presence of appropriate observers during my procedure/operation/treatment for the advancement of medical education and care.

PATIENT AFFIRMATION

By signing this request form, I am indicating that I understand the contents of this document, agree to its provisions, and request the anesthetic(s) as set forth in #5 be performed. I know that if I have concerns or would like more detailed information, I can ask more questions and get more information from my attending physician. I am also acknowledging that I know that the practice of anesthesiology, medicine and surgery is not an exact science and that no one has given me any promises or guarantees about the designated procedure/operation/treatment or its results.
I fully understand what I am now signing of my own free will.

WITNESS TO AFFIRMATION AND SIGNATURE	DATE	TIME	PATIENT SIGNATURE (or Parent, Guardian or Representative)	DATE/TIME

SIGNATURE OF PHYSICIAN OBTAINING CONSENT _____ **DATE** _____ **TIME** _____

PHYSICIAN ATTESTATION

I Dr. _____, attest that this patient or the representative named above has been informed about the common foreseeable risks and benefits of undergoing the procedure as well as its reasonable alternative(s), if any.
Further questions with regard to this procedure have been answered to his/her apparent satisfaction.

PHYSICIAN SIGNATURE	DATE/TIME

UNIVERSITY HOSPITAL

Patient Label

INFORMED CONSENT AND AUTHORIZATION FOR ANESTHESIA