

## ANESTHESIA RECORD

Room # \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_

Date of Service  
(MM/DD/YY)

ASA <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;">1</td> <td style="width: 20px; height: 20px;">2</td> <td style="width: 20px; height: 20px;">3</td> <td style="width: 20px; height: 20px;">4</td> <td style="width: 20px; height: 20px;">5</td> <td style="width: 20px; height: 20px;">E</td> </tr> </table>	1	2	3	4	5	E	Post Op Dx _____ _____ Procedure _____ _____ _____ _____	PRINT Surgeon _____ CRNA _____ Weight <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr></table> . <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> Kg Lb NPO at _____				
1	2	3	4	5	E							
Allergies: _____ _____ _____												

[illegible]

POST ANESTHESIA CARE VITALS/NOTE:

Patient temperature on arrival to PACU greater than or equal to 36C/96.8 F? ☐ Yes ☐ No

☐ No apparent complications    ☐ Stable    ☐ Report given to responsible practitioner

BP     /   HR    RR    SpO<sub>2</sub>   Temp

## POST ANESTHESIA EVALUATION

Required after operative or other high risk procedure and/or as the patient recovers from moderate or deep sedation or general, regional Or monitored anesthesia. Evaluation must be completed when the patient has received sufficiently to answer the key questions related To the evaluation. Outpatients must be evaluated prior to discharge.

[illegible]

Anesthesia Clinician \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Surgeon Signature

\_\_\_\_\_  
Date

Anesthesia Start                      Anesthesia End

Procedure Start.                      Procedure End

*Affix Patient ID Label Here*

# CONSENT TO ANESTHESIA

Patient \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ AM / PM

I acknowledge that my doctor has explained to me that I will have an operation, treatment or 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 I would experience much less pain, discomfort or anxiety during my planned 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 anesthesia, procedure or treatment. Although rare, severe and unexpected complications with anesthesia can occur and include the remote possibility of *infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack, cardiac arrest, or death*. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified as they may apply to a specific type of anesthesia.

I understand that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor will do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthetic technique which involves the use of local anesthetics may not succeed completely and therefore, another technique may have to be used, including general anesthesia. Furthermore, 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 judgment indicates to be necessary under the circumstances.

<input type="checkbox"/> General Anesthesia	Expected Results	Total unconscious state, possible placement of breathing tube into throat or wind pipe
	Techniques	Drug injected into the bloodstream, breathed into the lungs, or by other routes
	Risks	Mouth, throat or jaw pain, hoarseness, injury to mouth, gums, lips, or teeth, awareness under anesthesia, injury to blood vessels or nerves, aspiration of stomach contents into lungs, pneumonia, nausea and vomiting, muscle soreness, injury to the eyes
<input type="checkbox"/> Spinal or Epidural Anesthesia or Analgesia with IV sedation	Expected Results	Temporarily decreased or total loss of feeling and/or movement to lower part of the body
	Techniques	Drug injected through a needle/catheter placed either directly into the spinal fluid (spinal) or immediately outside this space (epidural)
	Risks	Headache, backache, infection, persistent weakness or numbness, decreased blood pressure, residual pain, injury to blood vessels or nerves, unexpected high level of spinal anesthetic block (causing upper body weakness or numbness), local anesthetic toxicity causing sudden drop in blood pressure or convulsions
<input type="checkbox"/> Nerve Block Anesthesia or Analgesia with IV Sedation <input type="checkbox"/> Axillary block <input type="checkbox"/> Interscalene block <input type="checkbox"/> Femoral nerve block <input type="checkbox"/> IV regional (Bier block) <input type="checkbox"/> Other: _____	Expected Results	Temporarily loss of feeling and/or movement of a specific limb or area
	Techniques	Drug injected near nerves, providing loss of sensation to the area of the operation
	Risks	Infection, convulsions, persistent weakness or numbness, residual pain, soreness at injection site, injury to blood vessels or nerves, local anesthetic toxicity causing sudden drop in blood pressure or convulsions
<input type="checkbox"/> Monitored Anesthesia Care (local anesthesia with IV sedation)	Expected Results	Reduced anxiety and pain, partial or total amnesia
	Techniques	Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state
	Risks	An unconscious state, depressed breathing

I certify that I have, to the best of my ability, told the Anesthesiologist/CRNA obtaining consent of all major illnesses I have had, of all past anesthetics I have received and any complications of these anesthetics known to me, of any drug allergies I have, and of all medications I have recently taken, including aspirin, over-the-counter medications, pain medications, herbal supplements, and recreational street drugs. I have also responded truthfully to any additional questions asked by the Anesthesiologist/CRNA.

I understand that my anesthesia care will be given to me by or under the supervision of an attending Anesthesiologist or by a CRNA. If I am pregnant I understand that elective surgery should be postponed until after the baby is born. Although fetal complications of anesthesia during pregnancy are very rare, the risks to my baby include, but are not limited to, birth defects, premature labor, permanent brain damage and death of my newborn.

I have listened to \_\_\_\_\_ Anesthesiologist/CRNA explain the type(s) of anesthesia/analgesia I may receive, its benefits, and common foreseeable risks and consequences, as well as those of its alternatives and now accept his or her recommendation with the EXCEPTION of (check one):

☐ Type of Anesthesia refused \_\_\_\_\_ ☐ No exception to anesthetic recommendations

By signing this consent form, 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 chosen anesthetic(s), and that I have had ample opportunity to ask questions and consider my decision. I agree to the above provisions, and hereby consent to the administration of the above checked anesthesia services for my operation, treatment, or procedure. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the Anesthesiologist/CRNA.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Signature of Patient's Guardian or POA \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Witness to Signature of Patient or Guardian/POA \_\_\_\_\_

Anesthesiologist/CRNA: I have personally explained the above information to the patient, or the patient's representative if the patient is incompetent to consent.

Anesthesiologist/CRNA \_\_\_\_\_

Date \_\_\_\_\_