INFORMED CONSENT FORM
(Surgical Operation and Invasive Procedures)

Date: _____/_____/_____ SSB#:_____

Name: _____ D. O. B. _____/_____/_____

Sex: M / F Address: _____

Note: To be filed in patient's medical record along with Operation Progress Notation and Anesthesia report.

I. CONSENT TO SURGICAL OPERATION /INVASIVE ROCEDURE

I, _____,
(Name of patient – Print name in space provided)

authorize_____ the
(Anesthetic Provider)

administration of anesthetics with vigilant monitoring of my bodily functions.

I have been explained and I agree to permit the performance of one of the following anesthetic techniques suitable for my surgical procedure:

- **GENERAL ANESTHESIA** including and inhaled anesthetic agent, and (orointubation or laryngeal mask), which will cause unconsciousness, muscle relaxation, amnesia, analgesia

- **SEDATION CONSCIUOS OR DEEP** with intravenous or/and inhaled agents: sedation, amnesia, analgesia

- **REGIONAL ANESTHESIA**: (spinal, epidural, caudal, nerve block): needle insertion near centroneuraxis or major nerves, which temporarily cause me to loose sensations (motor and sensitive block) in certain areas of my body.

- **LOCAL ANESTHESIA**: including local anesthetic agents with or without sedation.

If my regional or local anesthetic technique is not satisfactory to me or my surgeon, I consent to the administration of general anesthesia.
I understand that during the course of an operation, unforeseen changes in my condition may arise which would necessitate changes in the care being provided to me. In that case, the anesthesia provider will act in my behalf with my safety as the first priority.
I am aware that the practice of anaesthesiology is not an exact science and that no guarantees can be made concerning the results of administration of anesthetics to me.

Anesthetic common side effects, complications and risks include, but are not limited to: nausea and vomiting, adverse drug reaction, bronchospasm, laryngospasm, arrythmias, dreams or recall of intraoperative events, corneal abrasions, and damage to mouth, teeth, or vocal cord, backache. Post-dural puncture spinal headache, massive block, neurological injury (caudia equine syndrome, numbness, pain or paralysis, epidural or spinal haematoma, meningitis, damage to arteries, veins and in rare cases permanent brain damage, heart attack, stroke, or death.

These potential risks apply to me whether I have general, regional or local anesthesia. In addition, I certify that I have, to the best of my ability, told the anesthesiologist/nurse anesthesia obtaining consent, of all major illness 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 taken in the past year.

I have also responded truthfully to any additional questions asked by the anesthesiologist. The nature and purpose of my anesthetic management have been explained to me, I have had the opportunity to ask questions, and the answers and additional information provided have met my satisfaction. I retain the right to withdraw this consent at any time prior to the administration of the anesthesia.

_____ _____/_____/_____
Anesthesia Provider *Date*

_____ _____/_____/_____
Signature of Patient or responsible party *Date*

_____ _____/_____/_____
Signature of Witness *Date*

II. TIME OUT VERIFICATION

Immediately prior to start of the operation/procedure, the patient was identified using two identifiers (name and SSB #), the correct surgical operation/procedure was verified, the written agreement was made by patient and or/ legal guardian.

_____
Signature of Anesthetic Provider

_____
Signature of ORN (if applicable)