

TO THE PATIENT: You have the right, as a patient, to be informed about 1) the recommended anesthesia/analgesia to be used and 2) the risks related to anesthesia/analgesia. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive anesthesia/analgesia in the perioperative period (meaning shortly before, during and shortly after a procedure). Please ask your physician/health care provider any remaining questions you might have before signing this form.

Administration of Anesthesia/Analgesia

The plan is for the anesthesia/analgesia to be administered by (note that the provider listed may change depending on the length of the procedure or other circumstances):

Check the planned approach and have the patient/legally authorized representative initial:

(Check one)

☐ _____ Physician Anesthesiologist Dr. _____ [Name] and/or associated Physician Anesthesiologist(s)

(Check all that apply if the administration of anesthesia/analgesia is being delegated/supervised by the above provider)

☐ _____ Certified Registered Nurse Anesthetist (CRNA) _____ [Name] and/or associated CRNA(s)

☐ _____ Physician in Training (Resident) _____ [Name] and/or associated Resident(s)

The above provider(s) can explain the different roles of the providers and their levels of involvement in administering the anesthesia/analgesia.

Types of Anesthesia/Analgesia Planned and Related Topics

- I understand that anesthesia/analgesia involves additional risks and hazards. The chances of these occurring may be different for each patient based on the procedure(s) and the patient's current health. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me.
- I understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest (heart stops beating), brain damage, paralysis (inability to move), or death.
- I also understand that other risks or complications may occur depending on the type of anesthesia/analgesia. The type of anesthesia/analgesia planned for me and the related risks for that type of anesthesia/analgesia include but are not limited to:

Check planned anesthesia/analgesia method(s) and have the patient/legally authorized representative initial.

☐ _____ GENERAL ANESTHESIA – injury to vocal cords, teeth, lips, eyes; awareness during the procedure; memory dysfunction/memory loss; permanent organ damage; brain damage.

☐ _____ REGIONAL BLOCK ANESTHESIA/ANALGESIA - nerve damage; persistent pain; bleeding/hematoma; infection; medical necessity to convert to general anesthesia; brain damage.

Location: _____

☐ _____ SPINAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ _____ EPIDURAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ _____ DEEP SEDATION – memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

☐ _____ MODERATE SEDATION – memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

Check if applicable and have the patient/legally authorized representative initial.

☐ _____ PRENATAL/EARLY CHILDHOOD ANESTHESIA - potential long-term negative effects on memory, behavior, and learning with prolonged or repeated exposure to general anesthesia/moderate sedation/deep sedation during pregnancy and in early childhood.

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*If List of Risks is used for this item, patient must initial the indicated risks. This form is designed to comply with the requirements promulgated by the Texas Medical Disclosure Panel

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND MRN IN SPACE BELOW

**DISCLOSURE AND CONSENT -
ANESTHESIA and/or PERIOPERATIVE
PAIN MANAGEMENT (Analgesia)**

Medical Record Form 6501–Rev. 08/23 (Page 1 of 2)
The University of Texas Medical Branch Hospitals
Galveston, Texas
Original–Medical Record

Additional comments/risks:

Granting of Consent for Anesthesia/Analgesia

In signing below, I consent to the anesthesia/analgesia described above. I acknowledge the following:

- I have been given an opportunity to ask questions I may have about:
 1. Alternative forms of anesthesia/analgesia,
 2. Steps that will occur during administration of anesthesia/analgesia, and
 3. Risks and hazards involved in the anesthesia/analgesia.
- I believe I have enough information to give this informed consent.
- I certify this form has been fully explained to me and the blank spaces have been filled in.
- I have read the form or had it read to me.
- I understand the information on this form.

If any of those statements are not true for you, please talk to your physician/health care provider before continuing.

PATIENT/OTHER LEGALLY AUTHORIZED REPRESENTATIVE (signature required)

Name (Print) Signature DATE: _____ TIME: _____ A.M.
P.M.

Legal relationship to patient: _____ Reason Patient is unable to sign: _____

Witness: _____
Print Name Signature
DATE: _____ TIME: _____ A.M./P.M.

Witness Address (Street or P. O. Box) City, State, Zip Code

Physician: _____
Print Name Signature
DATE: _____ TIME: _____ A.M./P.M.

If applicable: Interpreter's Printed Name Interpreter's ID# Interpreter's Company or UTMB Department Name