

Facility: **Elmhurst Hospital Center**

**INFORMED CONSENT FOR
ANESTHESIA AND/OR
SEDATION ANALGESIA**

Chart No.

Name

Unit

(Patient Imprint Card)

FORM B-2

I hereby authorize _____ (Name of Attending Physician or Authorized Health Care Provider) or his/her Associate Attending Physician and assistants as may be selected and supervised by him/her to administer:

Anesthesia

Sedation Analgesia

I have been informed of the risks, benefits and alternatives of the administration of such anesthesia and/or sedation analgesia and my questions have been answered to my satisfaction.

Signature of Patient or Parent/Legal Guardian of Minor Patient Date and Time am pm

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

Signature of Health Care Agent/Legal Guardian Date and Time am pm
(Place a copy of the authorizing document in the medical record)

Signature and Relation of Surrogate Date and Time am pm

WITNESS:

I, _____ am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

Signature and Title of Witness Date and Time am pm

INTERPRETER/TRANSLATOR: (To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

Signature of Interpreter/Translator Date and Time am pm

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**INFORMED CONSENT
PROGRESS NOTE**

**(The Informed Consent Form HHC 100 B-2
on the reverse side must also be completed)**

I explained the risks, benefits, side effects and options of the proposed anesthesia and/or sedation analgesia to the above-named patient.

As I explained to the patient, the risks, benefits, side effects, alternatives and intended goals of the anesthesia and/or sedation analgesia (including potential problems with recuperation) include but are not limited to:

Risks and Side Effects: - Respiratory Depression - Hypoxia - Apnea (breathing stops)

- Cardiac arrhythmias - Low blood pressure (hypotension) - Need for assisted ventilation

- Intubation - Dental Trauma - Emergence Reaction - Allergic reaction - Death

Benefits: - Decreased pain and anxiety - Decreased awareness of the procedure

Alternatives to Anesthesia and/or sedation analgesia (including the risks, side effects and benefits thereof):

- Local anesthesia - Intravenous or oral analgesic agents

- No sedation or pain management agents

I provided the above-named patient with the opportunity to ask questions. I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

Signature of Attending Physician or Authorized Health Care Provider*

Date and Time am pm

Print Name and Identification Number

IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIENT, THE ATTENDING PHYSICIAN MUST CERTIFY THAT THE PATIENT LACKS DECISIONAL CAPACITY.

ATTENDING ANESTHESIOLOGIST'S CERTIFICATION

I have examined the above-named patient and it is my professional medical opinion that this patient lacks decisional capacity to make informed health care decisions. I understand that if this patient has appointed a health care agent to make these decisions, a copy of the patient's Health Care Proxy must be inserted in the medical record. If the patient's surrogate has consented to the proposed treatment for the patient, the surrogate has signed the consent form.

Signature of the Attending Anesthesiologist

Date and Time am pm

Print Name and Identification Number

* Authorized Health Care Provider is one who is credentialed and privileged by the medical staff to perform this diagnostic test, procedure or surgery that requires informed consent. See also HHC Consent Policy, Article III.