Ophthalmology Anesthesia Services
Informed Consent For Anesthesia Services

My doctor has explained to me that I will have an operation or treatment procedure. He/she has also 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 my doctor can perform the 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 procedure or treatment. Although rare, unexpected severe 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, depressed breathing, heart attack, or death. I understand that these risks apply to all forms of anesthesia and that additional specific risks have been identified below as they may apply to a specific type of anesthesia. It is impossible to list all of the complications associated with anesthesia on this consent and therefore any specific complication a person experiences with an anesthetic may not be included on this form. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique, which involves the use of local anesthetics with or without sedation, may not succeed completely, at which point further evaluation will take place to determine additional measures to be taken.

The administration of regional anesthesia and surgery will require the cooperation of the patient and the patient must understand that unexpected movement by the patient during the administration of anesthesia and during the surgical procedure, whether sedated or not, may cause severe injury to the patient.

☐ **Major/Minor Nerve Block (regional anesthesia)** ☐ With sedation ☐ Without sedation _____ (Initials)	Expected Results	Temporary loss of feeling and/or movement of a specific limb or area.
	Technique	Drug injected near nerves Providing loss of sensation to the area of the operation
	Risks	Perforation of the eyeball, possible drooping of the eyelid, destruction of the optic nerve, interference with circulation of the retina, double vision , infection, convulsions, difficult or depressed breathing, weakness , persistent numbness, residual pain, injury to blood vessels or nerves, temporary or permanent loss of vision, allergic reactions to drugs, or hypotension(low blood pressure).

_____
(Initials)

_____ _____
Date Time

☐ **Monitored Anesthesia Care** (with sedation) _____ (Initials)	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, or by other routes, producing a relaxed, conscious state.
	Risks	An unconscious state, depressed breathing, injury to blood vessels, and allergic reactions to drugs.
☐ **Monitored Anesthesia Care** (without sedation) _____ (Initials)	Expected Result	Measurement of vital signs, availability of anesthesia provider for further intervention.
	Technique	None.
	Risks	Increased awareness, anxiety and/or discomfort.

I authorize the release of any medical information necessary to process my insurance claim.

I authorize payment of benefits for anesthesia services provided to Ophthalmology Anesthesia Services, LLC.

I hereby consent to the anesthesia service checked above and authorize that it be administered by _____/ Ophthalmology Anesthesia Services, all of whom are credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I expressly desire the following considerations to be observed (or write "none") _____.

I CERTIFY AND ACKNOWLEDGE THAT I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME, THAT I UNDERSTAND THE RISKS, ALTERNATIVES AND EXPECTED RESULTS OF THE ANESTHESIA SERVICE AND THAT I HAD AMPLE TIME TO ASK QUESTIONS AND TO CONSIDER MY DECISION.

Signature of Patient _____ Date_____ Time_____

When Patient is a minor or incompetent to give consent:
Patient is a minor_____ years of age or is unable to sign because _____

Signature of person authorized to give consent for Patient _____

Relationship to Patient_____ Date_____ Time _____

WITNESS: _____ Date_____ Time _____

Translator/Interpreter (Print Name, Address and Phone Number) _____

_____

I hereby certify that I have discussed the administration of anesthesia, risks, benefits and/or alternatives with the patient and/or their representative.

_____ CRNA Date_____ Time _____

_____
(Initials)

_____ _____
Date Time