

CQI Alerts

Feb
2006

OBSERVATIONS BY THE CONTINUOUS QUALITY IMPROVEMENT PROGRAM FOR UWMC ANESTHESIOLOGY



SPECIAL CONSENT TO ANESTHESIA / SEDATION

If you are providing MAC, sedation or anesthesia in the Radiology / Imaging Services area, make sure there's a signed consent for the following procedures:

- CAT scan
- Fluoroscopy
- MRI
- Ultrasound

When do I need to look for a consent?

- Is the procedure in the UWMC Radiology / Imaging Services area?
- Is this a "stand-alone" procedure, not part of a greater surgical procedure?
- Is this a non-emergent procedure?

If you can answer "yes" to all three of these questions for the procedures listed above, then you'll need to look.

This is the only time when Anesthesiologists must both check to see if a signed consent to treatment is present and also obtain consent for anesthesia / sedation.

What do I look for?

Look for a medical form titled:

- "Special Consent for Procedural Treatment" OR
- "Special Consent to Anesthesia/Sedation"

How long is the consent good for?

The signed consent is only good for the patient's current scope of treatment. Consents from previous hospital visits are not valid.

I couldn't find one, what now?

Get a "Special Consent to Anesthesia/Sedation" from the MRI Control Room SS232 or online at www.uwanesthesiology.org/protocols under the section for Radiology.

What does the consent look like?

SPECIAL CONSENT TO ANESTHESIA/SEDATION

Washington state law gives patients the right and the responsibility to make decisions about their health care. Doctors can give you information and advice, but the patient (or his/her "legally authorized representative") must be part of the decision-making. This form confirms permission for treatment recommended by the patient's doctor.

I understand that I/the patient _____ will have _____ **Print Patient Name**

_____ **Full Name of Procedures**
a diagnostic or treatment procedure, for which anesthesia or sedation services are needed. I have spoken with my/the patient's doctor about the test or procedure itself.

I understand that my/the patient's doctor may choose assistants, including residents, to help with my/the patient's anesthesia or sedation services. At this time, I understand that my/the patient's doctor expects these assistants to be: _____ **Print Names of Expected Assistants**

These assistants may perform tasks including (as applicable) _____ and the following additional tasks (if applicable): _____

I understand that at the time of my/the patient's actual procedure(s), unanticipated changes may mean that my/the patient's doctor needs to choose different assistants or have the assistants do different tasks.

I have had the following things explained to me, and I have had a chance to ask questions and to have my questions answered:

1. The kind of anesthesia or sedation to be used.
2. The expected results of the anesthesia or sedation and the general chance of having these results happen. I understand that results cannot be guaranteed.
3. Possible other forms of anesthesia or sedation, and alternatives to anesthesia, analgesia or sedation.
4. Expected benefits of the anesthesia or sedation and of the possible other forms and alternatives.
5. Serious possible risks and complications of the anesthesia or sedation and of the possible other forms and alternatives. This includes side effects from medicines and problems with recovery. I understand that all anesthetics involve risks of complications and possible serious damage to vital organs such as the brain, heart, lung, liver and kidney. In some cases, these may result in paralysis, cardiac arrest and/or brain death. I understand that dental damage may occur as a risk of anesthesia. I understand that nerve damage may occur as a risk of anesthesia positioning.
6. I understand that my/the patient's doctors may learn confidential information from or about me/the patient during the procedure(s) and/or treatment.
7. I have received the following additional detailed information about the treatment (if applicable): _____
8. I have received a patient information packet for _____ (if applicable)

Continued on Reverse

PN ID _____
NAME _____ Place EPIC Label Within Box
DOB _____

UW Medicine
Harborview Medical Center - UW Medical Center
University of Washington Physicians
Seattle, Washington

SPECIAL CONSENT TO ANESTHESIA/SEDATION

1/22/05

UH2227 REV DEC 05

CONS ENT - GRAY

Note: The consent is two pages long.