

SPECIAL CONSENT FOR ANESTHESIA/SEDATION

The law in Washington gives you the right and the responsibility to make decisions about your health care. Health care professionals can give you information and advice. You or your legal representative must be part of the decision-making. This consent form:

- Proves that you had a part in making decisions about your health care.
- Shows that you gave permission for the treatment recommended by your doctor.

The words "I", "my", etc., in this form refer to the patient, no matter whether the patient or the patient's representative is signing the form. The term "health care professional" may mean the attending physician, but in addition may mean a different doctor (including a resident), nurse practitioner, registered nurse or physician assistant, who orders, performs all or part of, or is involved in explaining the procedure.

I understand that I will have _____

_____ **Print Full Name of Procedure/Treatment**

which is a procedure where anesthesia or sedation services are needed. I have spoken with my health care professional about the test or procedure itself.

Dr. _____ will be the doctor in charge of my anesthesia or sedation.

_____ **Print Anesthesia Doctor's Name**

I understand that the anesthesia health care professional may choose assistants, including residents (doctors who have finished medical school, but are getting more training), to do or help with my anesthesia or sedation. The assistants may do other tasks that the anesthesia health care professional has discussed with me as applicable. If known, the anesthesia health care professional has discussed with me whether there will be assistants and who s/he expects the assistants to be. I understand that during the anesthesia procedure, the anesthesia health care professional may need to choose different assistants or have them do different tasks. I understand that for some kinds of medical equipment used during anesthesia procedures, a representative from the equipment manufacturer may be there, doing things like providing consultation or running checks on the equipment.

I have received this added detailed information and/or a patient information sheet about the anesthesia or sedation:

_____ **Print added Information or name of information packet**

I understand whether I will receive either anesthesia or sedation medicine, or both. I have been told about my options for anesthesia and sedation and about their risks and benefits. I have been told about side effects of the medicine(s) and problems they may cause with recovery.

I understand that anesthesia and sedation medicines involve risks. These risks can be serious. They may include damage to vital organs such as the brain, heart, lungs, liver, and kidneys. They may even result in paralysis, cardiac arrest, brain damage, and/or death.

I understand that the anesthesia equipment may damage my teeth or cause other dental damage.

I understand that nerve damage may occur from how anesthesia equipment is placed or how my body must be positioned during a procedure while I am anesthetized or sedated.

I understand that I am free to refuse consent to any proposed treatment.

PLACE PATIENT LABEL HERE

UW Medicine

Harborview Medical Center – University of Washington Medical Center
UW Neighborhood Clinics – Valley Medical Center
University of Washington Physicians Seattle, Washington

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Interpreter (**Print Name**) _____

Giving Consent

By signing below, you confirm that you have read the sections above and that you have had 1) each item explained to you; 2) a chance to ask questions; and 3) all of your questions have been answered.

SIGNATURE (PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE)		PRINT NAME		DATE	
IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:					
<input type="checkbox"/> 1. Guardian	<input type="checkbox"/> 2. Durable Healthcare Power of Attorney	<input type="checkbox"/> 3. Spouse/registered domestic partner			
<input type="checkbox"/> 4. Adult Child(ren)	<input type="checkbox"/> 5. Parent(s)	<input type="checkbox"/> 6. Adult Brother(s)/Sister(s)			
<input type="checkbox"/> 7. Adult Grandchild(ren)	<input type="checkbox"/> 8. Adult Niece(s)/Nephew(s)				
<input type="checkbox"/> 9. Adult Aunt(s)/Uncle(s)	<input type="checkbox"/> 10. Adult Friend with executed Declaration per RCW 7.70.065				
FOR MINOR PATIENTS:					
<input type="checkbox"/> 1. Guardian/legal custodian	<input type="checkbox"/> 2. Court-authorized person for child in out-of-home placement	<input type="checkbox"/> 3. Parent(s)			
<input type="checkbox"/> 4. Holder of signed authorization from parent(s)		<input type="checkbox"/> 5. Adult representing self to be a relative responsible for the minor's health			
WITNESS (OPTIONAL)		PRINT NAME		DATE	TIME
<input type="checkbox"/> TELEPHONE MONITORED	Name of authorizing person (Check relationship to patient above)				

HEALTH CARE PROFESSIONAL'S STATEMENT

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative before the patient and/or his/her representative consented.

If only the patient has signed this form, in my clinical opinion, the patient is capable of making his/her own health care decisions. If in my clinical opinion, the patient has questionable ability to make his/her own health care decisions, I discussed the above with the patient and with the following legally authorized representative:

<input type="checkbox"/> 1. Guardian	<input type="checkbox"/> 2. Durable Healthcare Power of Attorney	<input type="checkbox"/> 3. Spouse/registered domestic partner
<input type="checkbox"/> 4. Adult Child(ren)	<input type="checkbox"/> 5. Parent(s)	<input type="checkbox"/> 6. Adult Brother(s)/Sister(s)
<input type="checkbox"/> 7. Adult Grandchild(ren)	<input type="checkbox"/> 8. Adult Niece(s)/Nephew(s)	
<input type="checkbox"/> 9. Adult Aunt(s)/Uncle(s)	<input type="checkbox"/> 10. Adult Friend with executed Declaration per RCW 7.70.065	

HEALTH CARE PROFESSIONAL SIGNATURE	PRINT NAME & TITLE	UPIN/NPI (IF APPLICABLE)	DATE	TIME
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PLACE PATIENT LABEL HERE

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University of Washington Physicians Seattle, Washington

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