BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Anesthesia for Imaging

This information is given to you so that you can make an informed decision about having **anesthesia for imaging.**

Reason and Purpose of this Procedure:

Your doctor wants you to have imaging to diagnose or treat a problem. You and your doctor have decided that anesthesia should be given before the imaging. There may be concerns related to you being unable to tolerate the scan. These might be pain, claustrophobia, (fear of closed spaces), inability to stay still or other reasons.

Benefits of this Procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Increased tolerance during the scan.
- Ability to complete the scan.
- Reduces patient awareness and recall of the Imaging.
- Allows proper muscle relaxation for longer periods of time.

General Risks of Anesthesia:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- **Complications with extubation (removing the breathing tube)**. You may need placement of an airway device and further monitoring.
- **Damage to teeth with intubation (placement of the breathing tube)**. This can occur even if you have good teeth.
- **Nausea and vomiting**. Your provider can discuss medicines to help decrease this.
- **Sore throat**. This is usually temporary. Lozenges and fluids can help.
- **Headache**. This is usually temporary. Your provider can discuss medicines you can take.
- **Shivering**.
- **Delayed return to normal mental functioning**. Some people take longer than others to get over the effects of the medicine used. You will be monitored watched closely until you return to normal.
- **Death**. You will be continually monitored with lifesaving equipment ready for use.

Risks Associated with Smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Specific to You:

_____

_____

_____

Alternative Treatments:

Other choices:

- Refuse anesthesia and have the scan without sedation.
- Refuse both anesthesia and the scan.

If you Choose not to have this Treatment:

- Your doctor may find it more difficult or not possible to treat your problem.

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By signing this form, I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Anesthesia for Imaging** _____

  _____
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with the procedure. The tasks will be based on their skill level. My doctor will supervise them.

Patient Signature: _____ Date: _____ Time: _____

Relationship: ☐ Patient ☐ Closest relative (relationship) _____ ☐ Guardian/POA Healthcare

Reason patient is unable to sign: _____

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

Telephone Consent ONLY: *(One witness signature MUST be from a registered nurse (RN) or provider)*

1st Witness Signature: _____ 2nd Witness Signature: _____ Date: _____ Time: _____

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back:

Patient shows understanding by stating in his or her own words:

_____ Reason(s) for the treatment/procedure: _____

_____ Area(s) of the body that will be affected: _____

_____ Benefit(s) of the procedure: _____

_____ Risk(s) of the procedure: _____

_____ Alternative(s) to the procedure: _____

OR

_____ Patient elects not to proceed: _____ Date: _____ Time: _____

(Patient signature)

Validated/Witness: _____ Date: _____ Time: _____