	FORM	CODE:	FT-AH-194
CLINICA DE MARLY *Cuida su Salud*	**INFORMED CONSENT FOR ANESTHETIC PROCEDURES**	**VERSION:**	1
		ISSUANCE DATE:	06/18/2018 mm/dd/yyyy

The Doctor …….. has informed to me that for the surgical intervention referred to as ……, upon assessment of my medical records and supplementary tests, some of the following types of anesthesia may be administered to me: GENERAL ANESTHESIA AND/OR LOCAL ANESTHESIA AND/OR MONITORED ANESTHETIC CARE, SEDATION.

Main benefits of anesthesia are:

- Reduce the probability of traumatic memories associated with the intraoperative period.
- Control the response of your heart, lungs, brain and other organs with regard to intraoperative surgical stress.
- Provide appropriate physical conditions for the surgeon to carry out a surgery.

Anesthetic cases have the following risks for patients:

Nauseas, vomit, shivers, allergies, arrythmias, blood pressure alterations, laryngeal spasms, or bronchial spasms, aspiration of stomach's contents into the lung, dental injury and/or oral injury, pressure areas, neurological injuries, inflammation of layers covering nerves (arachnoiditis or neuritis), transitory and/or permanent nerve injury, post-tap headache, infections, renal injuries, need for a change in anesthetic technique, cardiovascular complications, cardio-respiratory arrest, death.

The questions I have asked relating to potential complications in my specific case have been answered and I have understood the information provided. These complications consist of: ……
……..……
……..…, as well as the possibility of a change in the anesthetic technique as required.

I have been informed of some of the circumstances that may require special monitoring (intravascular catheter), blood transfusion, or the need for intensive care during the post-operative period.

I had the opportunity to ask questions, and any concerns and doubts relating to the anesthesia have been clarified.

I know that the anesthesiologist who held the pre-anesthesia consultation and recorded the information on my medical record is not necessarily the same anesthesiologist that will apply the anesthesia during the surgical intervention and the respective anesthesiologist is hereby authorized to make any modifications, according to his professional judgement as required.

_____	_____
Name of patient or relative/guardian* *Kinship	Signature ID No.:
_____	_____
Witness* *kinship	Signature ID No.:
_____	_____
Name of physician	Signature ID No.:

Date _____

This document shall be included in the Patient's Medical Record.