(Fill out in the absence of label)

Hospital Name _____

Full Name: _____

Date of birth: ___/___/_____ Age: _____ Gender: ____ Bed: _____

Admission Date: ___/___/_____ Time: _____ Registration: _____

Chief Medical Officer: _____ CRM: _____

CONSENT FOR ANESTHESIA

I hereby declare that I was informed about the main aspects related to anesthetic procedure to which I'll be submitted to at this organization.

I authorize the anesthesiologist identified below, or any other member of his team, all duly registered by this institution, to perform the following anesthetic procedure _____ or the following anesthetic alternative _____

I declare that:

a) I am aware that to carry out the procedure (s) proposed, the use of anesthesia will be necessary. Its methods, techniques and drugs are indicated by the anesthesiologist. The alternative (s) to the anesthetic procedure indicated to enable the procedure to be performed; its benefits, risks and complications were explained to me satisfactorily.

b) I was informed that anesthesia involves invasive procedures that can cause injury that most often are temporary. Permanent damage are rare but can occur even if the procedure has been carried out under the most rigorous technical standards. I was also informed that the response to drug administration is individual and that the occurrence of collateral or unwanted effects is unpredictable.

c) I understand that there is no absolute guarantee of the results to be obtained, but that all resources, drugs and equipment available in this institution will be used.

d) I authorize any other procedure, examination, treatment and / or surgery, including blood transfusion in case of unforeseen situations that require different care of those initially proposed.

e) On the occasion of this consent, I have informed the anesthesiologist on pre-existing conditions, medications in use, surgeries, anesthesia complications and allergic reactions previously presented and also on the fasting time elapsed (since the last meal / fluid intake)

f) I was informed by the medical team that smoking, the use of narcotic drugs, such as cocaine, marijuana, amphetamines, and other drugs like alcohol are factors that can bring harm to the procedure and / or treatment. I was also informed of the complications that can result from the use of these substances.

g) I declare that I have been duly informed regarding an eventual need of blood transfusion and

- ☐ I authorize blood transfusion
- ☐ I do not authorize blood transfusion due to the following reasons: _____

I am aware that the record of my refusal regarding blood transfusion will be submitted to the medical staff that will carry out the proposed procedure for reassessment of the viability of the conduct proposed.

PATIENT/REPRESENTATIVE:

I confirm that I had the opportunity to ask questions, I received sufficient explanation, read and I understand and agree with all the information I was enlightened with and I was given the opportunity to override, question or change any item, paragraph, or words which I did not agree with.

Location _____ Date Month _____ Year 20_____ Time: _____

Legible name: _____ Signature: _____

Representative relatedness to the patient: _____ CPF (ID number): _____

WITNESS

Legible name: _____ Signature: _____

TO BE FILLED OUT BY THE PHYSICIAN

I confirm that I have explained the purpose, benefits, risks, and alternatives to the treatment described in details to the patient and /or representative or family member. I believe that the patient / representative understood what I explained.

_____

*Legible name, CRM and 'check' or stamp with CRM and 'check' *(physician's license number)*

TO BE FILLED OUT BY THE PHYSICIAN IN CASE OF BLOOD TRANSFUSION REFUSAL

On the refusal to carry out a blood transfusion, the medical team decided to:

- ☐ Decline the case, recommending: _____
- ☐ Proceed with the completion of the proposed procedure with the use of alternative methods
- ☐ others _____

_____

*Legible name, CRM and 'check' or stamp with CRM and 'check' *(physician's license number)*