

EPIDURAL ANESTHESIA

Epidural anesthesia is a technique of regional anesthesia in which an anesthetic drug is injected through a needle positioned between two vertebrae of the back into the epidural space, an area next to the spinal cord. A specific amount of anesthetic drug is given to bathe the nerve roots as they exit from the spinal cord. Because of diffusion of drug across tissue barriers, it may take from 10 to 30 minutes for the nerve blockage to occur. Effective anesthesia can be produced to allow below the waist surgeries or births without discomfort. The patient remains awake during this type of anesthesia.

Patient's
Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of epidural anesthesia have been discussed with me and may include but are not limited to:

- *backache*
- *bleeding*
- *blood pressure changes*
- *drug reaction*
- *failure of epidural to be effective and need for general anesthesia*
- *respiratory distress*
- *headache*
- *infection*
- *minor pain and muscle aches*
- *nerve injury*
- *paralysis*
- *seizures*

_____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exists with any surgical procedure.

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____ I understand and accept the use of epidural anesthesia during my surgical procedure or for the delivery of my unborn child.

_____ I am aware and accept that no guarantees have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform the following procedure of _____
(procedure name and brief description)

_____ on _____ at _____
(patient name) (name of facility)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

_____ Patient or Legal Representative Signature/Date/Time	_____ Relationship to Patient
_____ Print Patient or Legal Representative Name	_____ Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

_____ initial	_____ copy given to patient	_____ Physician Signature/Date/Time	_____ original placed in chart	_____ initial
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