Life Guard Anesthesia
Safety. Comfort. Assurance.

(ANESTHESIA INSTRUCTIONS FOR YOUR PROCEDURE)

Please follow these instructions to help us provide the safest anesthesia possible for you or your family member.

DAY BEFORE THE PROCEDURE

- Make sure you have completed your packet checklist and remember to bring the packet with you.

- Please refrain from eating or drinking at least 8 hours prior to your arrival time.
    - **Pediatric Patients Only**: Children may have small amounts (6 – 12 ounces total) of apple juice or other clear juices (no pulp or soda) up to 2 hours prior to their arrival time. It is perfectly safe for children to fast prior to anesthesia just like adults, they just might be a little more irritable.

- Unless your dentist/surgeon has asked you to avoid certain medications, please take all your prescribed medications on their normal schedule, including narcotics or anti-anxiety medications. Take them with as little water as possible.
    - **Diabetic Patients Only**: Please do not take your regular insulin. You may take any of your oral medications. ***If you have an afternoon appointment***, you may eat a liquid only breakfast at least 6 hours prior to your arrival time.

- Wear a loose fitting top, as we will need to place various monitors on your chest and side, and have access to your arms for the placement of an IV catheter. Also please bring a second set of clothing.

MORNING OF PROCEDURE

- Please brush your teeth thoroughly prior to your arrival, avoid swallowing anything.

- Make sure to bring your completed anesthesia packet with you.
- You must have a driver to take you to and from your appointment. You cannot drive for 24 hours following anesthesia. If you do not have someone to take you home, your procedure will be cancelled.

If you fail to follow these instructions, your procedure may have to be postponed or cancelled. These guidelines are for your safety.

AFTER YOUR PROCEDURE

- You may be sleepy for the rest of the day. This is normal. Please make sure someone is with you for the next 24 hours.

- You can return to a normal diet, or the diet that has been indicated by your dentist/surgeon. We recommend you start with lighter foods, so you don't become nauseated after anesthesia.

We look forward to the opportunity of taking care of you or your family member. We pride ourselves in excellent patient care and satisfaction. You will be receiving a phone call in the evening to follow-up on your anesthesia care and to see how you are doing. If you have any questions, please email us at Questions.lifeguard@gmail.com. We will respond within 24 hours.

Thank you and we look forward to serving you.

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CONSENT FOR ANESTHESIA SERVICES

I, _____, acknowledge that my doctor has explained to me that I will have an operation or procedure performed, and has explained the risks associated with this procedure. I also understand that anesthesia services are needed so that my doctor can perform this procedure.

It has been explained to me that all forms of anesthesia carry some risks and no guarantees or promises can be made concerning the result of my procedure. Although rare, unexpected *severe complications* with anesthesia can occur and include the remote possibility of *infection, bleeding, drug reactions, loss of sensation, paralysis, stroke, brain damage, heart attack, or death*. I understand these risks apply to all forms of anesthesia and that specific risks related to the type of anesthesia I will be receiving are explained further below. I will be receiving:

Monitored Anesthesia Care (with moderate or deep sedation)

Expected Result	Reduced anxiety and pain, partial or total loss or memory, moderate to deep levels of sedation
Technique	Drug injected into the bloodstream, either by intravenous access or intramuscular injection
Risks	An unconscious state, depressed breathing, injury to blood vessels

I hereby consent to the anesthesia service listed above and authorize that it be administered by the associates of LifeGuard Anesthesia Services Incorporated, all of whom are licensed and credentialed to provide anesthesia services in the state of Oklahoma and in this healthcare facility. I also consent to any alternative type of anesthesia, if necessary, as deemed appropriate by them.

I certify and acknowledge that I have read this form or had it read to me; that I understand the risks and expected results of the anesthesia service; and that I had ample time to ask questions and to consider my decision.

_____ _____ _____

Patient's Signature or Authorized Rep. *Date and Time* *Relationship to Patient*

_____ _____, CRNA

Witness Signature *Anesthesia Provider's Signature*

A list of commonly used drugs for anesthesia is listed on the back of this form.

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- Propofol and **Ketamine** are short-acting hypnotic/sedatives. These drugs are administered to put you into a state of unconsciousness or sleep. The depth of this sleep varies based on the amount given by your anesthesia provider and the level required for you procedure. Some of the desired effects, and some rare side effects, are listed.

Desired effects can include:	**Undesired effects can include:**
- Sedation	- Drops in blood pressure or increases in blood pressure
- Amnesia	- Slowed breathing
- Reduced anxiety	- Changes in heart rhythm or arrhythmias
- Pain relief	- Seizures
	- Increased salivation

- **Versed** is a short acting drug given to reduce anxiety, cause amnesia, and put the patient in a relaxed state. Some of the desired effects, and some rare side effects, are listed.

Desired effects can include:	**Undesired effects can include:**
- Drowsiness	- Dizziness
- Reduced anxiety	- Nausea/Vomiting
- Amnesia	

- Fentanyl is a strong narcotic given to reduce or eliminate pain related to your procedure. Some of the desired effects, and some rare side effects, are listed.

Desired effects can include:	**Undesired effects can include:**
- Drowsiness	- Slowed breathing
- Reduced pain	- itching
- Relaxation	- Nausea/Vomiting

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(PRE-ANESTHESIA QUESTIONNAIRE)

Name:_____Date of Birth: _____ Sex: □ M □ F Age: _____

Date of Procedure: _____ Office Name: _____Ht: _____Wt:_____

Best Phone Number to Call: _____Primary Care Doctor, if any:_____

Allergies to Medications, Supplements, or Foods: □ **No Known Allergies**

_____

_____

Do you currently have or have you ever had:

Cardiovascular:

Yes	No	
□	□	High Blood Pressure
□	□	Peripheral vascular disease
□	□	Atrial Fibrillation
□	□	Heart Attack: when _____
□	□	Chest pain/Angina – how often _____
		If yes, how treated _____
□	□	Murmur /history of Rheumatic fever
□	□	Pacemaker or Implanted defibrillator
□	□	History of Congestive Heart Failure

Respiratory:

□	□	Asthma – last ER visit _____
□	□	COPD
□	□	Sleep Apnea/CPAP/BIPAP
□	□	Shortness of breath
□	□	Can you walk one flight of stairs without stopping?

Gastrointestinal:

□	□	Hiatal Hernia
□	□	Acid Reflex (GERD)
□	□	Hepatitis
□	□	Other GI/Liver problem-_____

Musculoskeletal:

□	□	Arthritis: Rheumatoid or Osteoarthritis
□	□	Back or Neck pain
□	□	Difficulty walking

Hematologic:

□	□	HIV+
□	□	Sickle cell – disease or trait
□	□	Bleeding/Easy bruising
□	□	Blood thinners
□	□	History of blood clots

Genitourinary:

□	□	Kidney Disease
□	□	Dialysis: Hemo/peritoneal (M T W TH F)

Neurological:

Yes	No	
□	□	Stroke or TIA – when _____
□	□	Paralysis – where _____
□	□	Parkinson's Disease
□	□	Epilepsy – last seizure _____
□	□	Alzheimer's or Dementia
□	□	Restless Leg Syndrome
□	□	Other neurologic condition- _____

Endocrine:

□	□	Thyroid: Hyper or Hypo
□	□	Diabetes –
		(circle) Insulin pills diet controlled

Females:

□	□	Are you pregnant?
		Last menstrual period _____
□	□	Tubal Ligation or Hysterectomy

General:

□	□	History of problems with Anesthesia
		If yes, what? _____
□	□	Mastectomy: Left Right
□	□	Do you smoke – how long? _____
□	□	Alcohol use
		how much/often?_____
□	□	Recreational Drug use
		type and last use_____

Pediatric Patients Only:

□	□	Is there someone who smokes in the home?
□	□	Currently sick? (Cold, Flu, Allergies)
□	□	Taking antibiotics? Date started-_____
□	□	Any family history of Malignant Hyperthermia?

Any other problems not previously mentioned?

_____

_____

_____

_____

Please fill out medication sheet and surgical history on the back of this page

MEDICATION AND SURGICAL HISTORY

CURRENT MEDICATIONS ☐ **Patient does not take any medications or supplements**

Please include: Prescriptions, OTC Medications, Nutritional Supplements, Vitamins, Herbs, Birth Control Pills, Patches, etc…
(Please do not use abbreviations)

Medication Name	Dose	Route	Frequency

Please include another sheet of paper if necessary

PAST SURGERIES ☐ **Patient has never had surgery**

Please include all surgeries regardless of age/year they occurred

Type of Surgery	Approx. Date	Problems if any?