



ANESTHESIA CONSULTANTS OF ARIZONA

We are honored to have the opportunity to provide anesthesia services for your upcoming procedure. In order for us to provide safe anesthesia care, please review the instructions included. There are some forms that will need to be completed prior to your arrival. The checklist below indicates what needs to be completed. **Bring this entire packet with you, with the checklist completed, to your appointment.** Failure to complete this list may delay, and in some instances, cancel your procedure. Payment for anesthesia services is required prior to your procedure. If you have any questions about any of this material, please email us at questions@acazgroup.com. We will respond within 24 hours, so be sure to email us early enough to receive a response. Our nurse will be available to answer additional questions when you check-in for your procedure.

Checklist:

- Read the preoperative instructions, nothing to eat/drink after midnight, except what is explained. Take any medications as explained.
- Fill out the pre-anesthesia questionnaire, front and back.
- Read the anesthesia consent form. We will go over this with you and sign it the day of your procedure.
- Please bring a check or debit/credit card to pay your anesthesia fee. Payment is required before services are given. **NO CASH PLEASE.**

If you do not know the anesthesia fee, please contact the office where the procedure will take place. They will have this information.

Thank you in advance for your cooperation in completing this packet. We look forward to serving you. Sincerely,

Aaron Ketcher, DNP, CRNA - President, Anesthesia Consultants of Arizona

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ANESTHESIA CONSULTANTS OF ARIZONA

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.
 - o **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.
 - o **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.

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. Be sure to hydrate yourself well after the procedure. This will help alleviate any side effects you may experience.

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@acazgroup.com. We will respond within 24 hours.

Thank you and we look forward to serving you.

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PRE-ANESTHESIA QUESTIONNAIRE

ANESTHESIA CONSULTANTS OF ARIZONA

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 | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Peripheral vascular disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Atrial Fibrillation |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack: when _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain/Angina – how often _____ If yes, how treated _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Murmur /history of Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or Implanted defibrillator |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Congestive Heart Failure |

Respiratory:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma – last ER visit _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | COPD |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea/CPAP/BIPAP |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Can you walk one flight of stairs without stopping? |

Gastrointestinal:

- | | | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hiatal Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Acid Reflex (GERD) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Other GI/Liver problem- _____ |

Musculoskeletal:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis: Rheumatoid or Osteoarthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Back or Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty walking |

Hematologic:

- | | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell – disease or trait |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding/Easy bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood thinners |
| <input type="checkbox"/> | <input type="checkbox"/> | History of blood clots |

Genitourinary:

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Dialysis: Hemo/peritoneal (M T W TH F) |

Neurological:

- | Yes | No | |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke or TIA – when _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Paralysis – where _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Parkinson’s Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy – last seizure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer’s or Dementia |
| <input type="checkbox"/> | <input type="checkbox"/> | Restless Leg Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Other neurologic condition- _____ |

Endocrine:

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid: Hyper or Hypo |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes – (circle) Insulin pills diet controlled |

Females:

- | | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Last menstrual period _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tubal Ligation or Hysterectomy |

General:

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | History of problems with Anesthesia If yes, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mastectomy: Left Right |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke – how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol use how much/often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Recreational Drug use type and last use _____ |

Pediatric Patients Only:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Is there someone who smokes in the home? |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently sick? (Cold, Flu, Allergies) |
| <input type="checkbox"/> | <input type="checkbox"/> | Taking antibiotics? Date started- _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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



ANESTHESIA CONSULTANTS OF ARIZONA

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)

Table with 2 columns: Category (Expected Result, Technique, Risks) and Description (Reduced anxiety and pain, partial or total loss or memory, moderate to deep levels of sedation; Drug injected into the bloodstream, either by intravenous access or intramuscular injection; 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 Anesthesia Consultants of Arizona, LLC, all of whom are licensed and credentialed to provide anesthesia services in the state of Arizona 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

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 your procedure. Some of the desired effects, and some rare side effects, are listed.

Desired effects can include:

- Sedation
- Amnesia
- Reduced anxiety
- Pain relief

Undesired effects can include:

- Drops in blood pressure or increases in blood pressure
- Slowed breathing
- Changes in heart rhythm or arrhythmias
- Seizures
- Increased salivation
- Headache

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:

- Drowsiness
- Reduced anxiety
- Amnesia

Undesired effects can include:

- Dizziness
- Nausea/Vomiting
- Headache

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:

- Drowsiness
- Reduced pain
- Relaxation

Undesired effects can include:

- Slowed breathing
- itching
- Nausea/Vomiting