I, __________________________ authorize the monitoring of vital bodily functions and the (and/or Responsible Party) administration of anesthetics to _____________ under the direction of a physician.

I have had explained to me and I agree to permit the administration of one or more of the following forms of anesthesia which may be suitable for the procedure I am about to have:

- **GENERAL ANESTHESIA** – including intravenous agents and inhaled gases, which will cause unconsciousness.
- **REGIONAL ANESTHESIA** – including needle injections near major nerves, which will temporarily cause me to lose pain sensations in certain areas of my body.
- **LOCAL ANESTHESIA** – including local anesthetic agents with or without intravenously administered sedatives.

If my regional or local anesthetic is not satisfactory to me or my surgeon, I consent to the administration of general anesthesia.

I understand that during the course of an anesthetic/operation, unforeseen changes in my condition may arise which would necessitate changes in the care being provided to me. In that case, the anesthesiologist will act in my behalf with my safety as the first priority.

I am aware that no guarantees can be made concerning the results of administration of anesthetics to me. Common side effects include: nausea, vomiting, headache, backache, sore throat or hoarseness, muscle soreness and soft tissue swelling. In addition, even minor surgery may carry with it major unforeseen anesthetic risks. These risks and complications include, but are not limited to, dreams or recall of intraoperative events, corneal abrasions, eye damage, damage to the mouth, teeth or vocal cords, pneumonia, numbness, pain or paralysis, damage to veins, arteries, liver or kidneys, adverse drug reactions and in rare cases, permanent brain damage, heart attack, stroke, or death. These potential risks apply to me whether I have general, regional, or local anesthetics.

If I am pregnant, I understand that elective surgery should be postponed until after the baby is born. Anesthetics cross the placenta and may temporarily anesthetize my baby. Although fetal complications of anesthesia during pregnancy are very rare, the risks to my baby include, but are not limited to, birth defects, premature labor, permanent brain damage and death.

I certify that I have, to the best of my ability, told the anesthesiologist/anesthetist obtaining consent, of all major illnesses I have had, of all the past anesthetics I have received and any complications of these anesthetics known to me. I have reported any drug allergies I have, and all medications I have taken in the past year. I have also responded truthfully to any additional questions asked by the anesthesiologist/anesthetist. I understand that I must not eat or drink anything after midnight the day prior to my anesthetic/surgery, unless otherwise directed by my anesthesiologist/anesthetist.

The nature and purpose of my anesthetic management have been explained to me. I have had the opportunity to ask questions, and the answers and additional information provided have met with my satisfaction. I retain the right to withdraw this consent at any time prior to the administration of said anesthetic.

Comments: ____________________________________________________________________________________________
_____________________________________________________________________________________________________

**Patient Signature:** _______________________________________________ **Date:** ______________________
**Responsible Party Signature (if applicable):** __________________________ **Date:** ______________________
**Relationship of Responsible Party to the Patient (if applicable):** __________________________
**Date:** ______________________
**Witness:** __________________________ **Date:** ______________________

PacifiCoast Ambulatory SurgiCenter
Conditions of Admission

Nursing Care
This center provides only general duty nursing care unless upon order of the patient’s physician the patient is provided more intensive nursing care. If the patient’s condition is such as to need the service of a special duty nurse, it is agreed that this must be arranged by the patient or his/her legal representative. The center shall in no way be responsible for failure to provide the same, and is hereby released from any and all liability arising from the fact that the said patient is not provided with such additional care.

Medical and Surgical Consent
The patient is under the care and supervision of his/her attending physician and it is the responsibility of the center and its nursing staff to carry out the instructions of such physician; the undersigned recognizes that all physicians and surgeons furnishing services to the patient, including the radiologist, anesthesiologist, and the like, are independent contractors and are not employees or agents of the center. The undersigned consents to X-ray examination, laboratory procedures, anesthesia, medical, surgical treatment, or center services rendered to the patient under the general and specific instructions of the physician.

Release of Information
To the extent necessary to determine liability for payment and to obtain reimbursement, the center may disclose portions of the patient’s record, including his/her medical record, to any person or corporation which is or may be liable, for all or any portion of the center’s charge, including but not limited to, insurance companies, health care service plans, and/or workers compensation.

Personal Valuables
It is understood and agreed that the center maintains a safe area for the keeping of money and valuables, and that the center shall not be liable for the loss or damage to any money, jewelry, documents, clothing, under garments, other articles of unusual value and small compass, and/or any other personal property, unless deposited with the center safekeeping.

Financial Agreement
The undersigned agrees, whether he/she signs as agent or patient, that in consideration of services to render to the patient, he/she hereby individually obligates himself/herself to pay the account of the center in accordance with the regular rates and terms of the center. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney’s fees and collection expense. All delinquent accounts shall bear interest at the legal rate.

Assignment of Insurance Benefits
The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the center or any insurance benefits of Unemployment Compensation Disability otherwise payable to the undersigned for this hospitalization at a rate not to exceed the center’s regular charges. It is agreed that payment to the center pursuant to this authorization, by an insurance company shall discharge said insurance company for any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Health Care Service Plans
This center maintains a list of the health care service plans with which it has contracted. A list of such plans is available upon request from the financial office. The center has no contract, express, or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full cost of all services rendered to him/her by the center if he/she belongs to a plan, which does not appear on the above-mentioned list.

**Patient Grievances**
Occasionally, situations may arise that are difficult to resolve. Thus, the grievance process is available to patients who wish to have a problem formally reviewed. The Grievance review will progress up to the Medical Director or his/her designee will be binding on all parties involved. To utilize the grievance procedure the patient submits a problem orally or in writing to the director of nursing (D.O.N.) within three working days after the problem becomes known to the patient.

The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.

**Policy on Patient Advanced Directives**
PCASC will not honor advanced directives. PCASC will resuscitate any patient in the facility, and once stable will transfer such patient to the nearest hospital.

An Advanced Directive protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions for yourself. You may request a copy of the California State Advance Directive from your medical provider.

**Initials**

**Acknowledgment of Driving Risks**
The undersigned understands that the procedure he/she will receive today may cause conditions that render driving unsafe. The undersigned has been informed by Pacific Coast Ambulatory SurgiCenter that he/she should not drive for at least ________ hours after receiving the procedure and that he/she should not attempt to drive until his/her symptoms have resolved. The undersigned understands that Pacific Coast Ambulatory SurgiCenter will assist in making alternative transportation arrangements if necessary.

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as the patient’s general agent to execute the above and accept its terms.

**Signature of Patient, Parent, or Guardian:**

(If other than patient, please indicate relationship): 

**Witness:**  

Dated: ________________
PacifiCoast Ambulatory SurgiCenter
Discharge Instructions
(949) 276-4141

1. Although you will be awake and alert in the recovery room, there will be a small amount of anesthetic in your body for at least 24 hours, and you may feel tired and sleepy for the remainder of the day. Once you are home, take it easy and rest as much as possible. It is advisable to have someone with you for the remainder of the day.

2. Eat lightly for the first 12 to 24 hours, and then resume a well-balanced normal diet. Drink plenty of fluids. Alcoholic beverages are to be avoided for 24 hours after your anesthesia or intravenous sedation.

3. Nausea or vomiting may occur in the first 24 hours. Lie down on your side and breathe deeply. Prolonged nausea, vomiting, pain, excessive bleeding, or drainage should be reported to your surgeon immediately.

4. Medications, unless prescribed by your physician, should be avoided for 24 hours. Check with your surgeon, and/or anesthesiologist for specific instructions if you have been taking daily medication.

5. Your surgeon will discuss your post surgery instructions with you and prescribe medication for you as indicated. You will receive additional instructions specific to your surgical procedure prior to leaving the surgery center.

6. Do not operate a motor vehicle or any mechanical or electrical equipment for 24 hours after undergoing anesthesia.

7. Must be discharged to and transported by a responsible adult.

8. Do not make any important decisions or sign legal documents for 24 hours following undergoing anesthesia.

9. If any problems arise please call Dr. _____________________________ phone: (949) 276-4141.

10. Other Instructions __________________________________________

11. Prescriptions: As Directed

665 Camino De Los Mares, # 100C
San Clemente, CA 92673
~ Patient Copy ~
1. Although you will be awake and alert in the recovery room, there will be a small amount of anesthetic in your body for at least 24 hours, and you may feel tired and sleepy for the remainder of the day. Once you are home, take it easy and rest as much as possible. It is advisable to have someone with you for the remainder of the day.

2. Eat lightly for the first 12 to 24 hours, and then resume a well-balanced normal diet. Drink plenty of fluids. Alcoholic beverages are to be avoided for 24 hours after your anesthesia or intravenous sedation.

3. Nausea or vomiting may occur in the first 24 hours. Lie down on your side and breathe deeply. Prolonged nausea, vomiting, pain, excessive bleeding, or drainage should be reported to your surgeon immediately.

4. Medications, unless prescribed by your physician, should be avoided for 24 hours. Check with your surgeon, and/or anesthesiologist for specific instructions if you have been taking daily medication.

5. Your surgeon will discuss your post surgery instructions with you and prescribe medication for you as indicated. You will receive additional instructions specific to your surgical procedure prior to leaving the surgery center.

6. Do not operate a motor vehicle or any mechanical or electrical equipment for 24 hours after undergoing anesthesia.

7. Must be discharged to and transported by a responsible adult.

8. Do not make any important decisions or sign legal documents for 24 hours following undergoing anesthesia.

9. If any problems arise please call Dr. __________________________ phone: (949) 276-4141.

10. Other Instructions _____________________________________________

11. Prescriptions: As Directed

I have received and read and understand these discharge instructions.

Patient Signature: ________________________________________________

Witness: ___________________________ R.N.

665 Camino De Los Mares, # 100C
San Clemente, CA 92673
Acct. Number:       Admit Date:       Admit Time:       

Patient Name:       

Birthdate:          Age:            Sex:            

Home Phone #:       S.S. #:         

Patient Address:    

Nearest Relative:   
Relation:           
Home Phone:        
Business Phone:     
In Emergency Notify: 
Home Phone:        
Bus. Phone:        

Admitting Physician: 
Address: 665 Camino de los Mares Suite 100C, San Clemente CA 92673 
Phone Number: (949) 276-4141
Admit By:            
Admitting Diagnosis: 
Discharge Date:      Time:            
Transfer to:         
Final Diagnosis:     

Operations & Procedures:
Patient Pre-Anesthesia Questionnaire

Name: ____________________________  Age: __________  Weight: __________

Person Accompanying You Home From Surgery: __________________________________________

Relationship to You: ____________________________ Telephone number: ______________________

YES  NO

--- 1. Have you ever had any type of anesthesia in the past?
--- 2. Have you or any family members had a problem with anesthesia?
--- 3. Are you allergic to medications? If so, which ones?
--- 4. Do you use any medications, drugs, or eye drops?
--- 5. Have you taken any steroid medication in the past six months?
--- 6. (Female patients of childbearing age) Are you pregnant?
--- 7. Do you smoke? If so, how much?

Have you ever had any of the following?

--- 7. High blood pressure?
--- 8. Chest pain (angina)?
--- 9. Palpitations (arrhythmia)?
--- 10. Heart disease?
--- 11. Diabetes?
--- 12. Thyroid disease or goiter?
--- 13. Asthma, TB, or other lung problems?
--- 14. Seizures, convulsions, blackouts, fainting spells, or stroke?
--- 15. Jaundice, hepatitis, or liver problems?
--- 16. Bleeding or clotting problems?
--- 17. Kidney problems?
--- 18. Recent fever, cold, cough, or sore throat?
--- 19. Do you drink alcohol? How much?
--- 20. Do you have loose teeth, dentures, bridges, capped teeth or crowns?

Additional comments or concerns___________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please date and sign this form on the day of your pre-operative visit.

Today’s date: __________________

Patient’s signature: ________________________________________________________________

Parent or Guardian’s signature (if applicable): ____________________________________________
Post-Operative Anesthesia Instructions

1. You must have an adult drive you home from the SurgiCenter to your place of destination. You will not be allowed to drive yourself or take a cab.
2. All patients, for a minimum of 24 hours following surgery, must make arrangements for post-operative care.
3. The effects of anesthesia can persist for 24 hours. You must exercise extreme caution before engaging in any activity that could be harmful to yourself or others.
4. Please avoid the use of alcoholic beverages for the first 24 hours and while taking pain medication.
5. You must follow your surgeon’s instructions as indicated for specific surgery instructions. Notify your surgeon of any unusual changes in your condition.
6. Take only the prescribed medications that your surgeon has given you for your post-operative care.
7. Diet may be as tolerated, or indicate from your post-operative instruction list.

I certify that I have read and completely understand the above instructions.

Patient’s signature: ________________________________

Parent or Guardian’s signature (if applicable): ________________________________

Patient is being released to: ________________________________

Current time: _____________________________________________

Today’s date: ___________________________

Witness: _____________________________________________
We are very careful to maintain your privacy and our patient’s confidentiality. Family members or friends may be calling to check on your status during your care at our facility. By law we are unable to release any information regarding your status without your consent. Please complete the bottom portion of this form if you would like information regarding your care released to your relatives or friends.

Please note that only the listed family members and friends will receive information regarding your medical care.

I, ______________________ on ___________ (today’s date) give my permission to Pacific Coast Ambulatory SurgiCenter to release information regarding my care to the following individuals:

1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________
5. __________________________________________________________
6. __________________________________________________________
7. __________________________________________________________
8. __________________________________________________________

Patient Signature: ________________________________