THIS SHADED SECTION FOR OFFICE USE ONLY:

T 011 803 0016 F 011 803 6957 www.AIPA.co.za aipa@bellevy.co.za

ANAESTHETIC CONSENT FORM

Acc Message: .....

ANAESTHESIOLOGIST: ..... DATE: ..... Acc No: .....

Hospital Sticker

Designed by specialists
for specialists

CONSENT UPDATED BY:
BEL LEVY & ASSOCIATES (PTY) LTD

HOSPITAL ..... SURGEON .....

PROCEDURE: ..... CODE .....

PREMED / Emrg / A LINE / CVP / PRONE / H&N / <1YR / <28D / PCA / ICU / BMI / BLOCK PL / BLOCK PR

W / T 0011 1215 1218 0032 0034 0043 0044 1221 1204 0018 2800 2802

ICD 10 How? Where? ..... Weight: ..... Height: .....

BPC TIME 0039	THEATRE TIME 0023 0025
START..... h.....	START..... h.....
END..... h.....	END..... h.....
TOTAL.....	TOTAL.....

Sections A, B and C must be completed by the person responsible for the account.

NAME OF PATIENT : _____ TITLE : _____

DATE OF BIRTH : _____ ID No : _____

OCCUPATION : _____ AGE : _____

PARTICULARS OF PERSON RESPONSIBLE FOR ACCOUNT :

SURNAME : _____ TITLE : ____ SIGNATURE : _____

FULL NAMES : _____

OCCUPATION : _____ ID No : _____

RELATIONSHIP TO PATIENT : _____ LANGUAGE: _____

POSTAL ADDRESS : _____ HOME ADDRESS : _____

_____ _____

_____ CODE : _____ _____ CODE : _____

TEL No (H) : _____ TEL No (W) : _____ (FAX) : _____

E-MAIL: _____ (CELL) : _____

EMPLOYER'S or BUSINESS NAME : _____

BUSINESS ADDRESS : _____

_____ SPOUSE TEL No : _____

NAME OF MEDICAL AID : _____

MEMBER NAME : _____ Med Aid No : _____

PLAN : _____ AUTH No : _____

FAMILY MEMBER OR FRIEND NOT LIVING WITH YOU IN CASE OF EMERGENCY :

NAME : _____ TEL No (H) : _____ (W) : _____

Please sign on this side!

CONSENT FOR ANAESTHESIA AND AGREEMENT BETWEEN THE AIPA MEMBER WHO IS A SPECIALIST ANAESTHESIOLOGIST AND YOU THE PATIENT.
THIS FORM HAS BEEN COMPILED WITH THE SAFETY OF YOUR ANAESTHETIC IN MIND.

1. I confirm that I have been informed of the purpose of anaesthesia and I confirm that the risks and complications generally associated with anaesthesia have been explained to me. I understand the anaesthetic options offered to me and have made my choice.
2. I understand that no one can guarentee an incident free anaesthetic.
3. I understand that there is equipment and theatre staff supplied by the hospital which cannot be guaranteed by the anaesthesiologist. I exempt the anaesthesiologist from any adverse managed care requirements of my medical aid as required by the Health Professions Council of South Africa.
4. I agree to not drink alcohol, drive a car, or operate other dangerous equipment; make important decisions or sign contracts for 24 hours after recovery from anaesthesia.
5. I authorise the release of any clinical information, including my HIV status to any other member of the medical and paramedical profession responsible for my safety and treatment.
6. I agree to allow my personal data to be forwarded to the relevant organisations as required by law and to allow anonymous data of a clinical and practice management nature, to be collected to help improve the patient healthcare experience.
7. I understand that my anaesthetic will be administered by a Specialist Anaesthesiologist.

PAYMENT

1. I agree to pay the fee (which may be a multiple or a percentage of the Reference Price List (RPL)) uniquely determined by the anaesthesiologist as required by the anti competitive rules established by the Department of Trade and Industry for the Health Industry.
2. I am aware that the Reference Price List (RPL) is available to view on www.doh.gov.za or 012 338 9300
3. I understand that the doctor may offer a discount for early settlement i.e. 30 days from date of service.
4. The fee is due and payable immediately on completion of the service. The account is rendered directly to you as required by the Medical schemes act No: 131 of 1998. This account is completely separate from those of the hospital, casualty, surgeon and any other medical accounts.
5. I understand that I remain personally responsible for payment of the account as per this agreement. I understand that I have a separate agreement with my medical aid which may not fully reimburse me.. Upon payment a receipt will be issued on request to enable me to claim a refund from my medical fund. I AM RESPONSIBLE FOR SUBMITTING THE ACCOUNT TO MY MEDICAL AID AND I UNDERTAKE TO SUBMIT THE ACCOUNT.
6. There can be no unilateral changes to this agreement.
7. I agree that interest will be charged in accordance with the National Credit Act under incidental debt up to 2% per month on accounts that have not been settled. I understand that payments on outstanding accounts shall be allocated in the following way interest, costs and then capital.
8. I also undertake to pay all legal, debt collection and tracing costs on the attorney and own client scale and charges as stipulated by the Debt Collectors Act 114 of 1998 relating to the recovery of fees outstanding on my account in respect of anaesthetic and other professional services rendered.
9. I consent to sharing information on my account with other credit grantors and with the credit bureau.
10. I confirm that the nominated postal address is correct for the purpose of receiving the account. I agree that should this address change I will give one week's prior written notice for such change to become effective.
11. I hereby choose the nominated address as my DOMICILUM CITANDI ET EXECUTANDI (My personal legal postal address) for all purposes under this agreement and I agree that any notice sent to the nominated address by prepaid registered post will be deemed to have been received by me on the third business day after the posting of it. I further agree that any notice received by me by any means and at any address will be valid for all legal purposes notwithstanding that it was not sent by registered post or to my DOMICILUM CITANDI ET EXECUTANDI. I agree that should I wish to change my DOMICILUM CITANDI ET EXECUTANDI I will give one week's prior written notice for such change to become effective.

I have read and understood the contract. I confirm that the particulars furnished by me on all of the pages are in all respects true and complete.

SIGNATURE (Patient/Guarantor/Guardian) _____ PLACE _____ DATE _____

WITNESS 1. _____ 2. _____

All information is treated as confidential.

HAS THE PATIENT EVER HAD THE FOLLOWING:	Circle one	DETAILS
ALLERGY / unusual reaction to medicines/injections/food?	YES NO	
MEDICINES / PILLS Are you presently taking any? Specify	YES NO	
Including any homeopathic medicines? Specify	YES NO	
Have you taken any Aspirin in the last two weeks? If so, when?	YES NO	
Previous anaesthetics (if so, when and what operation)	YES NO	
Problems with previous anaesthetics (details please)	YES NO	
Any family member with anaesthetic problems (what?)	YES NO	
Porphyria, malignant hyperthermia or scoline apnoea	YES NO	
Cortisone Treatment in past 12 months	YES NO	
Heart disease (eg. Chest pain, heart attack, rheumatic fever)	YES NO	
High blood pressure	YES NO	
Asthma, bronchitus or emphysema	YES NO	
Recent cold, cough or flu	YES NO	
Diabetes or thyroid problems	YES NO	
Jaundice or hepatitis (If so, when?)	YES NO	
Kidney or bladder disease	YES NO	
Heartburn, hiatus hernia, peptic ulcer	YES NO	
Muscle weakness or auto immune illness	YES NO	
Epileptic convulsions / stroke or blackout of any sort	YES NO	
Tendency to bleed or bruise easily	YES NO	
False, loose, crowned or chipped teeth (if so, where?)	YES NO	
Do you have any infections at present?	YES NO	

Weight _____ Age _____ Height _____ Are you pregnant? (if so, how long?)

Do you smoke? (if so, how many per day?) Alcohol consumption: nil/social/moderate/heavy

When last did you eat _____ H _____ and drink fluids _____ H _____

Is there anything else you feel your anaesthesiologist should know?

Please sign overleaf!

aspen PHARMACARE

O/E PRE-OP

BP PR
COLOUR TEMP
OED JVP
TEETH
H&N
A/W
CVS
RESP
GIT
OTHER
ASA
PREMED

SPECIAL INVESTIGATIONS

CXR
ECG
Hb WCC
INR PTT
Pit Bl. Gluc
Na K
Cl CO
U Cr

MONITORING

ECG		Ur Cath	
Oxim		NG Tube	
NIPB		Bld Warm	
CO_2		Ext Warm	
CVP		Temp	
Art			

VENTILATION

S M

MASK HME
LMA SIZE
ETT SIZE O / N
A/E CUFF PACK
Circuit
Ventilator
V_E R
P_I V_T
$FI O_2$ PEEP

TIME							TOTAL
DRUGS 1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
GAS FGF $FiO_2(N_2O$ / Air)							
H / I / S / D %							
IV FLUIDS							
220 F_1O_2							
Vtxf							
200 pH							
pCO_2							
180 pO_2							
HCO_3							
160 BE							
Hb							
140 K							
120							
100							
80							
60							
40							
SPO_2							
Co_2							
CVP							
Dextrostix							
Temp °c							
Events (1) (2) Etc							
Blood Loss							
Urine Output							

LINES (Type & Size) Site

1 ..... G .....
2 ..... G .....
3 ..... G .....
4 .....

EVENTS & POST OP:

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