



**Larke**  
**MEDICAL**

# Anaesthetic Pre-Operation Form

Dr MJ Venter 0923176 (PTY)LTD

Name \_\_\_\_\_

ID number \_\_\_\_\_

Email \_\_\_\_\_

Mobile \_\_\_\_\_

Date of surgery \_\_\_\_\_

My name is Dr Marisa Venter, and I am going to be performing your anaesthetic for your surgical procedure. Please take the time to read through the consent form over the page as it contains valuable instructions as well as important information for you.

I would appreciate it if you could fill in the questionnaire below and either keep it with you until I see you, or, if possible, email both completed pages to [larkemedical@gmail.com](mailto:larkemedical@gmail.com) so that I can plan your anaesthetic according to your specific needs. If there is anything that you don't understand, just leave it out so that I can clarify for you in person.

Otherwise, if you have any concerns or queries that you'd like addressed beforehand, please feel free to email me at any time.

PROCEDURE BEING DONE			
HAVE YOU EVER HAD ANY OF THE FOLLOWING?	YES	NO	PLEASE PROVIDE DETAILS
ALLERGY TO FOOD OR MEDICATION			
SMOKING HOW MANY PER DAY?			
ALCOHOL SOCIAL/DAILY/WEEKEND BINGES/HEAVILY			
PREVIOUS OPERATIONS (PLEASE LIST ALL)			
PROBLEMS WITH PREVIOUS ANAESTHETICS			
FAMILY HISTORY OF ANAESTHETIC PROBLEMS			
PORPHYRIA/ SCOLINE APNOEA, MALIGNANT HYPERTHERMIA			
CHRONIC ILLNESSES DIABETES/HYPERTENSION/THYROID			
HEART PROBLEMS CHEST PAIN/ HEART ATTACK ETC			
LUNG PROBLEMS ASTHMA/ EMPHYSEMA/ BRONCHITIS			
KIDNEY/LIVER/MUSCLE PROBLEMS			
CHRONIC MEDICATIONS NAMES ARE VERY HELPFUL			
SNORING WITH/WITHOUT SLEEP APNOEA			
REFLUX HEART BURN/HIATUS HERNIA/PEPTIC ULCER			
STROKE OR MINI-STROKE			
FAINTING BLACKOUTS IN THE LAST YEAR			
ABNORMAL BRUISING/BLEEDING			
INFECTION COLD/FLU CURRENTLY			
LOOSE TEETH FALSE/ CROWNED/ CHIPPED			
CAN YOU CLIMB ONE FLIGHT OF STAIRS COMFORTABLY?			
ARE YOU PREGNANT? IF SO, HOW FAR?			
WEIGHT AND HEIGHT			
I CONFIRM THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND WILL REPORT ANY CHANGES OR ADDITIONAL INFORMATION THAT MAY ARISE:	FULL NAME:		
	DATE :		
	SIGNATURE:		

# Pre-Anaesthetic Consent Form



## EATING AND DRINKING

Having an empty stomach is very important for a safe anaesthetic. Even a cup of coffee beforehand can cause vomiting and potential aspiration. Consequently, please ensure that you do not eat or drink anything for six hours before your surgery unless your surgery is for an emergency condition.

## DRIVING

Even though you may feel very awake after your anaesthetic, the gases and medication we use can impair your judgement. It is therefore against the law to drive a car or operate any heavy machinery for 24 hours after an anaesthetic. Please therefore make sure you have someone to fetch you if you are being discharged the same day. For the same reason, it is also recommended that no alcohol be consumed, and no important decisions made within 24 hours of your anaesthetic or of post-operatively prescribed pain medications.

## CONSENT

By signing this document, you are giving me consent to perform an anaesthetic on you. This consent is only valid for the proposed procedure you are consenting to. Note that you may withdraw consent at any time before the commencement of the anaesthetic.

This may include a general anaesthetic, a nerve block, adjunctive procedures and/or combinations thereof. Please make sure you understand the plan that we discuss together beforehand and ask any questions that may be on your mind. Should your physical and surgical conditions change at any time during the anaesthesia, the anaesthetic plan discussed with you may need to alter in order to ensure your safety and comfort.

## RISKS AND LIABILITY

Every effort is made to ensure your safety and comfort at all times, but unfortunately an incident-free anaesthetic cannot be guaranteed. Complications of anaesthesia include, but are not limited to: sore throat, headache, hoarseness, injury to airway/vocal cords/teeth, nausea and vomiting, pneumonia and other lung problems, injury to nerves/blood vessels with resulting weakness/ sensory loss, adverse drug reactions/allergies, heart problems, awareness under anaesthesia, brain damage and loss of life.

Please take note that Larke Medical is separate from that of the hospital, its equipment, staff, and facilities as well as from that of the surgeon, and as such Larke Medical cannot be held liable for any negligence, failure, or shortcomings of the aforementioned.

## BLOOD

On occasion, the nature of the surgery or your condition may necessitate the transfusion of blood and/or blood products. By signing this consent, you are also consenting to a blood transfusion, should the need arise. If you do not agree to a transfusion, please do not sign this consent until you have discussed this with me beforehand, as I may decline to perform an anaesthetic for you if I consider you to be in a high-risk category.

## NERVE BLOCKS

Depending on the procedure being done, I may suggest the use of a nerve block either in isolation or in addition to a general anaesthetic. Nerve blocks provide excellent pain control and reduce the need for strong medications with unpleasant side effects. Examples of nerve blocks are epidural or spinal anaesthetics, brachial plexus blocks, wrist or ankle blocks etcetera.

Unfortunately, like all procedures that we do, nerve blocks may result in untoward complications or side-effects. These are very rare but can include (though not limited to): failure of the block to work properly, nerve damage resulting in loss of function or sensory change (which may be temporary or permanent), damage to surrounding structures during the procedure (blood vessels, lungs, muscles), allergic reactions to the local anaesthetic agent, headache, nausea or loss of life.

## FINANCIAL OBLIGATION

Please note that the anaesthetic account is separate from the hospital and surgeon accounts. Larke Medical charges base medical-aid-specific rates except in the case of Discovery Classic plans (since Larke Medical is on this network) and PMB conditions. Where the higher fees are rejected, we will attempt to motivate for the PMB coverage. If unsuccessful, we will discount to the base rates. Our aim is to avoid patients having to pay co-payments. Cash-paying patients will be charged Discovery Base rates and will need to make an arrangement to pay the account via EFT. We will contact you for reimbursement – where you will be personally responsible for payment of the account – in the following three circumstances:

1. Where your medical aid has paid our fee into your bank account
2. Where your medical aid short-pays or rejects in whole or part the claim made at your medical aid's predefined rates.
3. Where you are not on a medical aid or your medical aid coverage has lapsed

## PERSONAL INFO & DEFAULT

You are hereby giving consent for the Practice to use a national credit bureau database for tracing purposes if necessary. Should you or your guarantor fail to settle the account in full, the Practice may record you/your guarantor in default with a credit bureau. In the event of legal proceedings for the recovery of an unpaid account, you will be liable for the payment of legal fees at a rate agreed upon between the collection attorney and the Practice. You hereby consent to the jurisdiction of the

**By signing below, you hereby confirm that you have read & understood the above. Please do not sign if you have any concerns or queries or if there are things you do not understand.**

Name \_\_\_\_\_ Signature \_\_\_\_\_

Signed at \_\_\_\_\_ On Date \_\_\_\_\_

Relationship to patient (self/parent/guardian) \_\_\_\_\_

Name of Witness \_\_\_\_\_ Witness Signature \_\_\_\_\_