

## → Patient information

Information about anesthesia

Information about data protection

Questionnaire | Declaration of consent



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## Contact

OP-Zentrum Clinica Vita

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Hohenzollerndamm 28A

10713 Berlin

T: 030.86 09 99 10

F: 030.86 09 99 23

## Telephone hours

Mo-Fr 09:00-13:00

Dear Patient,

You are scheduled to undergo an operative procedure in our outpatient surgical center. In preparation for your planned surgery, we want to make you aware of the following:

**Please call us to schedule an appointment for your pre-operative meeting.**

**For this pre-operative meeting, please bring the following with you:**

- Completed anesthesia questionnaire
- Transfer form from your treating physician
- Your valid health insurance card
- Your personal ID
- Your allergy pass
- Medical reports, such as:
  - ECG (patients with heart / circulatory diseases)
  - Laboratory reports (patients with blood clotting disorders)

**Rules for taking medications:**

You will be informed during the pre-operative meeting.

**Your appointment for surgery:**

Please inquire one workday before your planned operation at the surgical center where your operation will take place.

**On the day of surgery:**

Please come to the indicated appointment for surgery on an empty stomach.

**If you do not, then we cannot perform anesthesia, and you will not be operated on!**

**An empty stomach means:**

→ **Up to 6 hours before the operation**

a small snack may be eaten (for example, a slice of white bread with jam and a glass of milk). After that, you are not allowed to eat anything.

→ **6 hours before the operation** do not smoke or eat anything (no sweets, chewing gum, fruit or dairy products).

→ **Up to 2 hours before the operation** you may drink water.

→ **Less than 2 hours before the operation** you are not allowed to eat or drink anything.

**Please bring the following with you on the day of your operation:**

- Your valid health insurance card
- All medical reports
- Medical aids prescribed by your surgeon, such as:
  - Crutches
  - Injections
  - Orthotics
  - Stockings

**Please leave jewelry, watches, wedding ring, etc. at home. Please remove nail polish / artificial nails.**

**Pick-up and care after surgery**

Please make sure that you can be picked up by family members or friends after surgery. If this is not possible, you must first clarify whether your health insurance provider covers the cost of medical transportation.

Under no circumstances are you allowed to travel home alone, either by car or by public transport. At home, an adult person has to be present to take care of you during the first 24 hours after surgery.

*We wish you all the best for your upcoming operation!*

Your SPREEDOCS team at the Clinica Vita



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*Please read the following information before your pre-operative meeting with the anesthesiologist.*

Dear Patient,

The planned procedure shall be performed under general anesthesia. If other anesthesia procedures are also considered, we will always clarify the advantages and disadvantages of these individual procedures. The following information is intended to prepare you for your pre-operative meeting with the anesthesiologist.

### Anesthesia

Anesthesia (general anesthesia) eliminates awareness and pain sensation during the operative procedure. From the beginning to the end of the anesthesia, the patient is in a sleep-like state. Anesthesia is initiated by injecting the medication into a vein. The injection is repeated for longer operative procedures. As an alternative to the injection of anesthesia, gaseous anesthetics are applied through a mask that rests on the mouth and nose (mask anesthesia). After you have fallen asleep, we will ventilate you with oxygen via a ventilation tube that sits on the larynx (larynx or laryngeal mask anesthesia) or is inserted into the trachea (intubation anesthesia). Intubation also reduces the risk of saliva or stomach contents flowing into the lungs. Muscle-relaxing medication is required to insert the tube, which also improves the operating conditions.

Combining general anesthesia with regional anesthesia can reduce the overall need for anesthetics, shorten the wake-up phase and ensure a largely pain-free time after the operation. If this is to be provided, we will inform you separately.

### Risks and possible complications from anesthesia

The anesthesiologist monitors body functions before, during and after anesthesia to prevent risks and complications that may result from the operative and the anesthetic procedures. Despite all precautions, it cannot be ruled out with absolute certainty that in rare cases wakefulness and extremely rarely pain can occur during anesthesia.

*Overall, the risks and complications listed below occur extremely rarely (of 10,000 anesthesia procedures there is at most one serious anesthesia incident possible):*

Breathing difficulties or circulatory reactions (e.g. breathing problems similar to asthma, a decline in blood pressure, or slowing of the heartbeat) rarely occur, and often can be remedied quickly. Serious intolerance reactions and other life-threatening complications, such as cardiovascular or respiratory arrest or occlusion of blood vessels (embolism) due to delayed blood clots, are very rare even in patients with previous health problems.

Intubation, or use of the laryngeal mask, may cause difficulty with swallowing and hoarseness. Injuries in the throat, larynx and trachea as well as damage to the vocal cords with permanent voice disorders (hoarseness) and shortness of breath are very rare. Tooth damage or tooth loss is particularly possible with loose teeth.

In the case of oral operative procedures, intubation is carried out through the nose. Thereafter, nosebleeds or problems with smelling may occasionally occur.

Rises in body temperature due to life-threatening metabolic derailment (malignant hyperthermia) are extremely rare. Immediate medicinal and intensive medical treatment is then necessary.

Temporary or permanent nerve damage (e.g. loss of feeling) as well as bruises and infections in the area of the puncture site of the venous cannula (e.g. syringe abscess, tissue damage), which require surgical treatment, are rare. Permanent paralysis or infections leading to severe general blood poisoning (sepsis) are extremely rare. Numbness (loss of feeling), paralysis or skin injuries of the arms and legs due to pressure or strain during the operation cannot be ruled out with absolute certainty, however these usually recede within a few months. Nausea and vomiting have become less common, and life-threatening incidents from inhaling vomit are very rare. Rarely, there is a spasmodic closure of the airways, which can often be controlled.



*Please follow the following important rules before you have your operation.*

#### Side and follow-up interventions

Preparatory, accompanying and subsequent measures (e.g. monitoring procedures, infusions, or the placement of an indwelling cannula / central venous catheter) are not free of risks. Despite all precautions taken in the production of foreign blood preserves, plasma derivatives and other blood products, risks of infection during their transmission / use cannot be excluded with certainty: Transfusions of your own blood avoids such risks, but is only suitable for certain operations and some but not all patients.

#### Eating and drinking before the operation

→ **At least one working day before the operation** – If you regularly take medication, please ask by telephone about which medication can / should be taken.

→ **Up to 6 hours beforehand**, a snack can be eaten (slice of white bread with jam, glass of milk).

→ **Less than 6 hours beforehand** you cannot smoke or eat anything (including no sweets, no chewing gum, no fruit, no dairy products).

→ **Up to 2 hours beforehand**, 1 or 2 glasses of clear liquid (tea, water), but no milk and no cloudy juices may be consumed.

→ **Less than 2 hours beforehand** you are not allowed to eat or drink anything.

→ Be sure to inform the anesthesiologist if you have eaten, drunk or swallowed anything less than 2 hours before the procedure. Non-conformance to the above rules about eating and drinking prior to your operation will result in our inability to perform anesthesia due to the danger to life, and the planned operation will be cancelled!

#### Also important before the operation

→ Please come to the surgery without makeup and do not use fatty face creams.

→ Please remove nail polish / artificial nails.

→ Take off contact lenses, teeth adjustment clips, rings, jewelry, piercings, hairpieces.

→ Immediately before the operative procedure, please empty your bladder and bowel in the restroom, if necessary.

#### After the procedure

In the case of outpatient operative procedures, the patient must be accompanied by an adult person. This person may be with the patient immediately after the procedure, if the patient is recovering in our recovery room, and must look after the patient during the first 24 hours after the procedure. The operated patient may only leave the surgical center after discharge by a doctor or the recovery room nurse. For 24 hours after the procedure, the patient is not allowed to drive a vehicle, to work on running machines, to drink alcohol or take sedatives, and should not make any important decisions.

The questionnaire at the end of this document relates to the patient. Please be sure to fill out the form before the pre-operative meeting with the anesthesiologist. Complete information is required to be able to tailor the anesthesia to the patient. All information given is subject to medical confidentiality and privacy requirements and will be handled with strict confidentiality.

You can also ask questions in advance by telephone and make an appointment with us for the consultation, which must take place at least one day before the operation. Based on your answers, we will propose the most suitable anesthesia procedure for you (the patient).

Ask the anesthesiologist about anything that interests you about anesthesia. You can also find more information at

**[www.spredocs.de/Narkose](http://www.spredocs.de/Narkose)**.



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→ **Information about data protection**

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Dear Patient,

The protection of your personal data is important to us. According to the EU General Data Protection Regulation (DSGVO), we are obliged to inform you about the purpose for which our practice collects, stores or forwards data. The following information also explains what rights you have in terms of data protection.

### 1. RESPONSIBILITY FOR DATA PROCESSING

Data protection officer: Karin Schröer at SPREEDOCS

Clinic: SPREEDOCS – OP-Zentrum Clinica Vita, Hohenzollerndamm 28A, 10713 Berlin

Contact details: Tel. 030 – 860 999 10; Fax: 030 – 860 999 23; Email: [info@spreedocs.de](mailto:info@spreedocs.de)

### 2. PURPOSE FOR DATA PROCESSING

Data processing is performed by law to meet the treatment contract between you and your anesthesiologist and the associated duties. For this, we process your personal data, particularly your health data. This includes medical history, diagnoses, therapy suggestions and diagnostic findings that we or other physicians collect. For these purposes, other physicians that are treating you may also provide us with data. The collection of health data is a prerequisite for your treatment. If the necessary information is not provided, careful treatment cannot be provided.

### 3. RECIPIENTS OF YOUR PERSONAL DATA

We only transfer your personal data to third parties if this is permitted by law or if you have consented to it. Recipients of your personal data may be, above all, other physicians, associations of statutory health insurance physicians, health insurance companies, health insurance medical services, medical associations and private treatment settlement offices. The transmission of data takes place predominantly for purposes of billing and payment of services performed on you, as well as for the clarification of medical and insurance-related questions. In individual cases, the transmission of data to other authorized recipients may also take place.

### 4. STORING YOUR DATA

We will only store your personal data for as long it is necessary to perform the treatment. Due to legal requirements, we are obliged to keep this data for at least 10 years after completion of the treatment. Other regulations may lead to longer storage periods, for example 30 years for X-ray recordings, according to Section 28 Paragraph 3 of the X-ray Ordinance.

### 5. YOUR RIGHTS

You have the right to receive information about the personal data relating to you. You can also request the correction of incorrect data. In addition, under certain conditions, you have the right to delete data, the right to restrict data processing and the right to data transferability. The processing of your data is based on legal regulations. Only in exceptional cases do we need your consent. In these cases, you have the right to revoke your consent for future data processing. You also have the right to complain to the Berlin Commissioner for Data Protection and Freedom of Information (Friedrichstrasse 219, 10969 Berlin) if you believe that the processing of your personal data is unlawful. The legal basis for the processing of your data is Article 9 Paragraph 2 lit. h) DSGVO in conjunction with Clause 22 Paragraph 1 no. 1 lit. b) Federal Data Protection Act.

**Patient Data:**

**Field for Doctor**

OP Date: \_\_\_\_\_  stat.  amb.  
Planned Procedure: \_\_\_\_\_  
Anesthesia: \_\_\_\_\_

**Medical History | Declaration of Consent**  
Please answer the following questions completely and correctly. Please tick where applicable, underline or supplement the information. Bring this important information with you to talk to the anesthesiologist. With your cooperation, you will help us to do the best for your safety!

**1. Personal data**  
Telephone Number: \_\_\_\_\_  
Mobile Number: \_\_\_\_\_  
Email: \_\_\_\_\_  
Height: \_\_\_\_\_ cm/in      Weight: \_\_\_\_\_ kg/lb  
Gender: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
PatientConceptID: \_\_\_\_\_

**2. Care at home after the outpatient procedure**  
Who will take you home after the procedure?  
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Telephone/Mobile: \_\_\_\_\_  
Who can guarantee your care during the first 24 hours after the procedure?  
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Telephone/Mobile: \_\_\_\_\_  
Where can you always be reached in the first 24 hours after the procedure?  
Address: \_\_\_\_\_  
Telephone/Mobile: \_\_\_\_\_  
Do you have a car with an available driver?  
 No     Yes

**3. State of Health | Illnesses**

a.	Have you recently been in medical treatment? If so, when and why? _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b.	Do you have or did you have within the last 4 weeks an infection, fever or vomiting (e.g. cold, gastrointestinal virus, etc.)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c.	Do you have or did you have an infectious disease (e.g. hepatitis, tuberculosis, HIV/AIDS)? If yes, which one? _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d.	Are you prone to nausea or vomiting (e.g. motion sickness on a boat or plane)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

**4. Medications**  
Are you currently taking medication on a regular basis? If yes, which ones?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(or provide your medication plan)

<b>5. Previous Surgical Procedures</b>		<input type="checkbox"/>	<input type="checkbox"/>
a.	Have there been previous operations? When   On what? _____ _____	No	Yes
b.	Have you recently had anesthesia, regional anesthesia or local anesthesia (e.g. at the dentist)? Were there any complications? If yes, which ones? _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Have you ever had nausea or had to vomit after previous operations?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c.	Have you ever received blood or blood components via transfusion?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d.	Have your blood relatives ever had any problems with anesthesia (e.g. high fever or malignant hyperthermia during / after anesthesia)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>6. Allergies</b>	Do you have allergies or hyper-sensitivity to certain substances (e.g. food, anesthetic or pain medication, disinfectants, bandages, iodine, latex)? Which ones? _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>7. Blood Coagulation</b>		<input type="checkbox"/>	<input type="checkbox"/>
a.	Do you or any of your blood relatives have issues with bleeding (e.g. bruising, bleeding gums) or to have blood clots after surgery?	No	Yes
b.	<b>Vascular Disorders</b> (e.g. varicose veins, circulatory disorders, aneurysm)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c.	<b>Vascular Occlusion</b> (e.g. thrombosis/embolism)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>8. Acute/Chronic Illnesses</b>		<input type="checkbox"/>	<input type="checkbox"/>
a.	<b>Heart Disease</b> (e.g. angina pectoris, heart attack, heart defects, heart valve, heart muscle disease, cardiac arrhythmia, shortness of breath by climbing stairs)	No	Yes
b.	<b>Circulatory and Vascular Disorders</b> (e.g. too high or too low blood pressure, stroke, thrombosis, circulatory disorders, varicose veins)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c.	<b>Lung and Respiratory Disorders</b> (e.g. bronchial asthma, chronic bronchitis, pneumonia, emphysema, sleep apnea / snoring disease, vocal cord / diaphragmatic paralysis) Others: _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d.	<b>Liver Disorders</b> (e.g. jaundice, fatty or hardened liver, gallstones)	<input type="checkbox"/> No	<input type="checkbox"/> Yes

e.	<b>Kidney Disorders</b> (e.g. kidney stones, bladder infection, kidney infection)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	9.	<b>Implants   Aids</b> (e.g. pacemaker / defibrillator, heart valve, stent, joint prosthesis, plastics, metal, silicone, hearing aid, contact lenses / glasses)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
f.	<b>Metabolic Disorders</b> (e.g. gout, diabetes)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	10.	<b>Dental Condition</b> (e.g. loose teeth, veneers, prosthesis, bridge, crowns, implants)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
g.	<b>Thyroid Disorders</b> (e.g. under or over function, goiter)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	11.	<b>Personal Habits</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
h.	<b>Esophagus, Stomach or Intestinal Disorders</b> (e.g. reflux disease, ulcer, constriction, heart-burn, indigestion)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	a.	Do you smoke? What do you smoke and how much each day? _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
i.	<b>Eye Disorders</b> (e.g. glaucoma or cataracts)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	b.	Do you drink alcohol? What do you drink and how much each day? _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
j.	<b>Nervous System, Mental or Muscular Disorders</b> (e.g. muscle weakness, seizures / epilepsy, paralysis, stroke, depression, frequent headaches, Parkinson's disease, multiple sclerosis)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	c.	Do you take sleeping pills or sedatives? Which ones? _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
k.	<b>Disorders of the Skeletal System</b> (e.g. spinal damage, joint diseases, shoulder-arm syndrome)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	d.	Did you or do you consume drugs? Which ones? _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
l.	<b>Other Existing Conditions or Impairments</b> (e.g. disabilities, osteoporosis, chronic pain, restless legs syndrome) _____ _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	12.	<b>Additional Medical Information:</b> _____ _____ _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
				13.	<b>Are you or could you be pregnant?</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes

#### Declaration of Consent

- I have read and understood the information sheet and I accept the data protection declaration.
- I have answered the questions about my medical history to the best of my knowledge.
- I have received and read the information in the accompanying document on outpatient anesthesia. I will follow the instructions indicated.
- I have informed my accompanying person about the content of the information in the accompanying document on outpatient anesthesia.
- I was able to ask the questions that were of interest to me during the pre-operative meeting with the anesthesiologist.
- My questions were completely and understandably answered by the anesthesiologist.

#### Notes of the anesthetist \_\_\_\_\_ from the pre-operative meeting

The following was discussed during the pre-operative meeting: anesthetic procedure; advantages and disadvantages compared with other methods; possible complications; special risk-related situations; additional and follow-up procedures; possible changes and extended procedures; as well as:

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#### Planned Type of Anesthesia:

- Laryngeal mask       Mask anesthesia       Intubation anesthesia
- Special procedure: \_\_\_\_\_

- I have carefully considered my decision. I hereby consent to the anesthesia planned for the intended operative procedure.
- I agree to any necessary changes or extensions to the anesthesia procedure as well as to any necessary related and follow-up procedures.
- I reject the following anesthetic procedure: \_\_\_\_\_

Location, Date, Time

Doctor Signature

Patient Signature \*

\* The signature of the patient, caregiver, authorized representative/guardian. If one parent signs alone, he/she also indicates with his/her signature that he/she has sole custody or that he/she acts in agreement with the other parent.

- The patient has received the separated information section and data protection information.
- The patient has received a copy of this medical history and consent form.