AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1a. *(Check all applicable boxes)*

X	OPERATION OR PROCEDURE		SEDATION
	ANESTHESIA		TRANSFUSION

1b. DESCRIBE

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. _____

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any are: _____
(If "none", so state)

6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes for medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and signif icant alternative therapies.

_____
(Signature of Counseling Physician/Dentist)

10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	*(Signature of Patient)*	*(Date and Time)*

11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	*(Signature of Sponsor/Legal Guardian)*	*(Date and Time)*

PATIENT'S IDENTIFICATION	*(For typed or written entries, give: Name -- last, first, middle; ID no.(SSN or other); hospital or medical facility)*	REGISTER NO.	WARD NO.

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