HEALTHCARE

CONSENT TO ADMINISTRATION OF ANESTHESIA

Patient: ______________________________

Date: ____________________ Time: ____________________ a.m. / p.m.

I hereby give my consent and authorize Dr. ______________________________; or such other physician designated by him, to administer an anesthetic agent in connection with the planned operation. If any unforeseen condition arises in the course of the operation calling in his judgment for procedures in addition to or different from those now contemplated, I further authorize him to do whatever he deems advisable.

I acknowledge that he has explained to me the nature of the anesthetic agent to be used, the means by which it is administered, the possibility and nature of risks and complications from its use, the alternatives available, if any, and that he has answered any questions which I have to my satisfaction.

____
Witness

____
Signature of Patient

____
Signature of Physician receiving consent

(If patient is unable to sign or is a minor, complete the following.)

____
Witness

____
Signature of person consenting for Patient

____
Signature of Physician receiving consent