TriState Health

CONSENT TO OPERATIONS, PROCEDURES, AND ANESTHETICS

1. I authorize the performance on (patient name)_____ of the following operation/procedure_____

   _____

   _____

   to be performed at the direction of (provider name)_____
2. I consent to the performance of operations and procedures, in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above-named provider or associates/assistants may consider necessary or advisable in the course of the operation and/or procedure.
3. I consent to the administration of such anesthetics and/or sedation that may be considered necessary or advisable by the provider responsible for this service.
4. The nature and purpose of this operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained. I hereby authorize and direct the provider or pathologist to use his/her discretion in the disposal of any severed tissue or members from my body at the time of operation, with the exception of

   _____
5. I understand that my Advance Directive will be suspended during surgery. (patient/legal intitials) _____

_____ Time_____ Date____/____/_____
Patient Signature

_____ Relationship to Patient _____ Time_____ Date____/____/_____
Witness Signature

_____ Time_____ Date____/____/_____
Provider Signature

PATIENT "NPO STATUS" STATEMENT

1. I certify that I (my child), as recommended by my provider, have had:

   _____ Nothing to eat or drink, including water, since midnight
   Initial

   _____ No alcoholic beverages to drink in twenty-four hours
   Initial
2. I certify that, to the best of my knowledge, my (my child's) physical condition remains unchanged from my (my child's) last examination, and that I (my child) do (does) not have a cold or any type of infection, presently.

_____ Time_____ Date____/____/_____
Patient Signature

_____ Relationship to Patient _____ Time_____ Date____/____/_____
Witness Signature

Patient Sticker