CONSENT TO OPERATION AND ANESTHETICS

1. I authorize the performance upon _____

   of the following procedure/operation _____

   _____

   to be performed under the direction of Dr. _____.

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 doctor or his associates or assistants may consider necessary or advisable in the course of the operation.

3. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service, with the exception of _____.

4. I consent to the observation and participation of nursing students and certified emergency medical technicians in the medical care provided for me while I am a patient at Tri-State.

5. I consent to the photographing and/or videotaping for the purposes of medical study, research or education.

6. The nature and purpose of the operation, 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 hospital pathologist to use his discretion in the disposal of any severed tissue or members from my body at the time of the operation with the exception of _____.

Witness_____ Signed_____
(patient or nearest relative when patient is a minor or when the patient is mentally/physically incompetent)

Date_____ Time_____ AM PM Physician's Signature_____

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PATIENT "NPO STATUS" STATEMENT

I certify that I (my child) as recommended by my physician have (has) had:

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

_____ No alcoholic beverages to drink for twenty-four (24) hours.

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 at present.

Witness_____ Signed_____
(patient or parent/guardian)

Date_____ Time_____

TSH-16-95