

**MEDICAL RECORD**

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

**A. IDENTIFICATION**

1a. (Check all applicable boxes)		1b. DESCRIBE
OPERATION OR PROCEDURE	SEDATION	
ANESTHESIA	TRANSFUSION	

**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 significant 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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