

Patient Name: _____

Out-Patient Anesthesia Consent

I, _____, hereby authorize the anesthesia department physicians and/or CRNA associates to administer anesthesia for my surgery. I have read, understood and will comply with all post operative and post anesthesia written instructions.

I will not drive home or use public transportation after my anesthesia for at least 24 hours. Someone I know will take me home and stay with me for at least 24 hours. I realize that impairment of full mental alertness may persist for several hours in the post anesthesia period and I will avoid any decision or activity post operatively which depends upon full concentration or mental judgment to insure safe completion of that activity. I will not drive a car, operate machinery, or ingest alcohol for twenty-four hours after leaving the surgical facility. I will have supportive postoperative care arranged prior to surgery.

The common problems that sometimes occur in anesthesia such as nausea, vomiting, sore throat, etc, have been explained to me and I understand them. I am advised that though problems are not expected, complications cannot be anticipated and that there can be no guarantee, expressed or implied, that there will be no complications.

Patient is a minor below 18 years of age, and we, the undersigned, are the parents or legal guardian of the patient and do hereby have legal authority to consent and do consent for the patient.

Print Name _____ Date _____

Signature _____

Witness _____

Patient Initials: _____