Procedure Consent

HENDRICK MEDICAL CENTER
1242 NORTH 19th STREET
ABILENE, TEXAS 79601-2316

I

CONSENT TO DIAGNOSTIC/THERAPEUTIC PROCEDURE

PATIENT: DENISON IDA M MR #: 521376 AGE: 64

1. I hereby authorize Dr. P PATE and whomever he may designate as his assistants, to perform upon (NAME OF PATIENT) DENISON IDA M the following: DIAGNOSTIC/THERAPEUTIC procedure: Triple-Lumen Ins or:

and if any unforseen condition arises in the coarse of the DIAGNOSTIC/THERAPEUTIC procedure calling on his judgement for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems medically appropriate.

2. The nature and purpose of the DIAGNOSTIC/THERAPEUTIC procedure, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

3. I consent to the administration of anesthesia to be applied by or under the direction of Dr. P PATE and to the use of such anesthetics as he may deem advisable.

II

I certify that I have read and fully understand to the best of my ability the above consent to DIAGNOSTIC/THERAPEUTIC procedure, that the explanations therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in before I affixed my signature.

IF PATIENT IS A MINOR AND UNABLE TO SIGN COMPLETE THE FOLLOWING:

Patient is a minor of the age of _____ , and I being the parent(s), guardian(s), custodian(s), of stated patient, do hereby consent to the above stated DIAGNOSTIC/THERAPEUTIC procedure(s).

Date and Time Permit Signed: Jul 11, 1997 0830 Pt. Room # 2710-2

Ida Denison

PT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE HAND WRITTEN SIGNATURE

WITNESS:

NAME:
Hand Written Please B Martinez RN

ADDRESS: 1242 NORTH 19TH STREET

CITY, STATE, ZIP CODE: ABILENE, TEXAS 79601

CONSENT TO DIAGNOSTIC/THERAPEUTIC PROCEDURE

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