**PreOperative Pregnancy Test Waiver**

□ I DECLINE a pregnancy test prior to my anesthetic and surgical

procedure

I acknowledge that the potential consequences of not having the test have been discussed with me and all questions have been answered to my satisfaction. I further acknowledge that I have the right to ask my physician further questions at any point during the course of my treatment and that my treatment should be delayed until these questions are answered.

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**Signature of Patient PRINT NAME**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date YYYY/MM/DD**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Substitute Decision Maker PRINT NAME**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date YYYY/MM/DD Relationship to Patient**