



## Waiver of Pre-Operative Pregnancy Testing

I, \_\_\_\_\_ (patient's name) have no reason to believe that I am pregnant. However, my doctor and anesthesia provider recommend preoperative pregnancy testing in all pre-menopausal and peri-menopausal women who have a history of missed or irregular menstrual periods.

\_\_\_\_\_ I understand that the anesthesia drugs that I will receive during my surgical procedure may cause complications with a pregnancy, including but not limited to birth defects in my unborn child if I am pregnant.

\_\_\_\_\_ I understand that even if a preoperative pregnancy test is done, a negative result does not absolutely guarantee that I am not pregnant.

\_\_\_\_\_ I understand that I have been given the opportunity to delay the proposed surgical procedure in order that I may obtain diagnostic pregnancy testing, but I have elected to proceed with the proposed procedure without undergoing pregnancy testing.

\_\_\_\_\_ I understand that by signing this waiver, I am releasing the facility, the doctor, anesthesia provider and their employees, agents, and assigns from any and all liability resulting from my failure to obtain a preoperative pregnancy test and any resulting harm to myself or an unborn child including but not limited to wrongful birth, birth defects, and or emotional distress.

\_\_\_\_\_ I confirm that I have had the opportunity to have all my questions asked and answered concerning the proposed procedure and proposed anesthetic and its potential effects on pregnancy.

\_\_\_\_\_ I confirm that I have elected to proceed with the proposed procedure.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date & Time

\_\_\_\_\_  
Anesthesia Provider Signature

\_\_\_\_\_  
Date & Time