

**THIS DOCUMENT IS REQUIRED TO BE ON-FILE AT ST. LOUIS EYE SURGERY & LASER CENTER PRIOR TO SURGERY**

1

I \_\_\_\_\_, am aware that because I am scheduled to receive anesthesia services, St. Louis Eye Surgery & Laser Center (SLES LC) requires the following:

1. I can NOT drive myself home after my procedure.
2. I must have a responsible adult present during my procedure. This person must receive and sign instructions and escort me home.
3. I should have a responsible adult available for 24 hours after the procedure.

I understand that it is my responsibility to make these arrangements before arriving at SLES LC for my procedure. **I understand that if these arrangements are not made prior to my arrival, my procedure may be cancelled.**

\_\_\_\_\_  
PATIENT/POA/RELATIVE/GUARDIAN – SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE

2

I \_\_\_\_\_, give permission for personnel of St. Louis Eye Surgery & Laser Center (SLES LC) to leave messages on the voicemail/answering machine of the telephone number(s) I have provided below as my contact number(s). SLES LC will call before surgery to pre-register and obtain a brief medical history. I understand that SLES LC may leave information on a message regarding pre-operative instructions for my procedure and a post-operative call to check my condition. SLES LC may also contact the individual(s) listed below to obtain my health information.

\_\_\_\_\_  
PATIENT/POA/RELATIVE/GUARDIAN – SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Contact Person(s)

\_\_\_\_\_  
Phone

3

I have received the SLES LC patient information booklet prior to my date of service and made particular note of information addressing my rights and responsibilities as a patient, information regarding a living will or advanced care directive, as well as information regarding potential physician ownership in SLES LC.

\_\_\_\_\_  
PATIENT/POA/RELATIVE/GUARDIAN – SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE