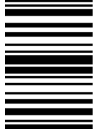
Authorization for Obstetrical Care



- ❑ I have read About Your Care During Labor and Birth.
- ❑ I understand what has been discussed with me, as well as the content of this form. I have been given the opportunity to ask questions and have received satisfactory answers.
- ❑ I understand that no guarantees or promises have been made to me about expected results of this pregnancy.
- ❑ I am aware that other risks and complications may occur. I also understand that during the remainder of m pregnancy, or during labor, unforeseen conditions may be revealed that require additional procedures.
- ❑ I know that anesthesiologists, pediatricians, resident doctors, and other clinical students/staff may help my doctor or midwife.
- ❑ I retain the right to refuse any specific treatment.
- ❑ All of my questions have been answered.

I consent to obstetrical care during my birthing experience. I understand that some of the procedures described above may occur. I retain the right to refuse any specific treatment. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.

Patient Name (print): ______________________ DOB or Patient ID#: ______________

Patient Signature: ______________________ Date: __________ Time: __________

Clinician Name (print): ______________________

Clinician Signature: ______________________ Date: __________ Time: __________

- ❑ I accept blood transfusions in the case of a life-threatening medical emergency.
- ❑ I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.

Patient Signature: ______________________ Date: __________ Time: __________

Form 1099-DMR, Rev, 9/3/10, MAH