ALASKA REGIONAL HOSPITAL

# ACKNOWLEDGEMENT
# INABILITY TO DRIVE HOME
# DAY OF SURGERY

PATIENT NAME_____

(Please Print)

I understand that because I am having a procedure/surgery and receiving anesthesia, I **will not** be able to drive myself home on day of procedure/surgery.

I will be having

DRIVER NAME_____

Accept responsibility for me and drive me home.

This responsible adult is: ❑ FAMILY ❑ FRIEND

❑ Person will be in the Waiting Room
❑ Please call this phone number_____

By signing this form, I understand that if my driver is not present when I check in for my procedure/surgery, the hospital will call and verify he/she is transporting me home. I also understand that if the hospital cannot verify that I have a responsible adult to transport me home, I will not be able to have my procedure/surgery.

Language line used for translation, Operator ID#_____

| | | |
|---|---|---|
| Patient Signature | Date | Time |
| RN Signature | Date | Time |
| Person Responsible for Patient - Signature/Relationship | Date | Time |



PLACE PATIENT LABEL HERE