Anesthesia Consent Verification for Spinal Surgery

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Procedure: Spinal Surgery

Dear [Insert Patient's Name],

This letter serves as verification of your informed consent for anesthesia administration during your upcoming spinal surgery scheduled for [Insert Date of Surgery].

We understand that you have discussed the risks, benefits, and alternatives associated with the anesthesia procedure with your anesthesiologist. You have also been provided with the opportunity to ask questions regarding the anesthesia plan.

Anesthesia Details:

- Type of Anesthesia: [Insert Type]
- Administration Method: [Insert Method]
- Expected Duration: [Insert Duration]

By signing below, you acknowledge that you have been informed about the anesthesia procedure and consent to its administration.

_____

Signature of Patient

_____

Date

Contact Information

If you have any questions or concerns, please do not hesitate to contact our office at [Insert Contact Number] or [Insert Email Address].

Sincerely,

[Anesthesiologist's Name]

[Title]

[Hospital/Clinic Name]