Consent to Administer Medications That Cannot be Positively Identified

I, the undersigned patient ________________________________ (the Patient), hereby authorize the ordering person to write an order for the use of the following unidentified medication, herbal remedy, vitamin or nutraceutical:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________.

I understand that my consumption of the above listed Product(s) may result in adverse or unforeseeable side effects, including side effects that may result from the interaction of the Product with my current medication regimen.

I understand that because the Product cannot be identified to the satisfaction of the ordering person, the Hospital cannot inform me with respect to:

• The intended purpose and use of the Product,
• The intended and unintended benefits of the Product,
• The quality of the Product,
• Whether the integrity of the Product has been maintained,
• The actual quality of active ingredients or possible contaminants in the Product,
• Whether the Product is what it is labeled to be, and
• The pharmacological effects of the Product and whether or not the Product is contraindicated given the patient’s current medication regimen.

I understand and acknowledge that it is against the ordering person’s medical advice for me to take this Product(s).

I understand that taking the Product identified above may endanger my life or health; I nonetheless request the administration of the Product.

I have been informed as to whether or not there are any alternatives to the Product that are available to the Hospital.

I personally assume the risks and consequences of refusal and hereby release Hartford Hospital, its agents and employees, students and medical staff, including but not limited to the ordering person, from any liability for any ill effects that may result from my decision.

All of my questions have been answered to my satisfaction.
I acknowledge that I have read this document in its entirety and that I fully understand it.

____________________________________  Date __________  Time ______

Signature of Patient/Legal Representative

____________________________________  Date __________  Time ______

Signature of Pharmacist

I, _______________________________ (the ordering person), certify that I have explained to the Patient the risks and consequences, to the extent known, associated with the taking of the Product identified above. The Patient has been given the opportunity to ask questions, and I have answered those questions. The patient/legal representative, in my opinion, has the ability to make an informed decision based upon the information provided.

____________________________________  Date __________  Time ______

Signature of Ordering Person

Interpreter responsible for explaining procedure and special treatment.

____________________________________  Date __________  Time ______

Signature of Interpreter