

McLaren Print System Order

Order No: 45533 Reprint Previous Order No: 5594
Order Date: 2019-05-22
User: Angela DeLaRosa
Phone: 9893164262

Ship Location: McLaren Bay Primary Care/Attn Angela DeLaRosa
4 Columbus Ave, Suite 380
Bay City, MI 48708

Forms

Quantity: 500
Paragon Dept No: 69050
Dept Name: McLaren Medical Group
Company Number: 810

Order Total Price: 0.00

Item Number: MM-113
Item Description: Consent for Office Procedure (Other than Routine Care)
Revision Date: 9/2018
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Medical Group
CONSENT FOR OFFICE PROCEDURE
(Other than Routine Care)

I hereby authorize and consent to the performance of the following procedure

by or under direction of Dr.
at (Facility's name) on (Date of procedure)

I further consent to the performance of any additional procedures during the course of my procedure which the physician or his designee judges necessary or desirable to correct the existing condition or any other unhealthy condition which they may discover.

I have been advised by my physician about alternatives to the procedure suggested, but I believe that the procedure suggested is the procedure I should have.

My physician has advised me fully about the nature of the procedure and the risks involved. I realize that neither the physician nor the facility can guarantee any result.

I have read this authorization and understand it.

NOTE TO PATIENT: YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND AGREED TO THE ABOVE, THAT THE PROCEDURE(S) HAS (HAVE) BEEN ADEQUATELY EXPLAINED TO YOU BY YOUR PHYSICIAN, THAT YOU HAVE ALL THE INFORMATION YOU DESIRE, AND THAT YOU AUTHORIZE AND CONSENT TO THE PERFORMANCE OF THE PROCEDURE(S) MENTIONED ABOVE.

DATE/TIME: SIGNATURE:

RELATIONSHIP (IF OTHER THAN PATIENT):

SIGNATURE OF WITNESS:

Signature of physician by which it is affirmed that the informed consent of the patient, or duly authorized agent, has been obtained to the outlined above.

DATE/TIME: SIGNATURE:

Time of pre-procedure Time out: Date
\* Patient identified
\* Operative site(s) verified/marked
\* Procedure verified
\* Skin-Prep-Dry Time Completed [ ] Yes [ ] No
Patient Physician

Witness
Date of Sign