McLaren Business Products

McLaren Print System Order

Order No: 52280 Reprint Previous Order No: 15771
Order Date: 2020-02-03
User: deborah simpson
Phone: 5864933670

Ship Location: Gratiot Medical Building
36500 Gratiot
clinton twp, mi 48035
Forms
Quantity: 500
Paragon Dept No: 37310
Dept Name: mt clemens womens health
Company Number: 260

Order Total Price: 0.00

Item Number: MO-113
Item Description: Consent for Office Procedure (Other than Routine Care)
Revision Date: 1/2016
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info:

McLaren Macomb

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 _____ on _____
(Facility's name) (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. Some significant and substantial risk of this particular procedure includes:

_____

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: _____
___Patient identified
___Operative site(s) verified/marked
___Procedure verified

Patient _____ Physician _____

CONSENT FOR OFFICE PROCEDURE