McLaren Business Products

McLaren Print System Order

Order No: 6207
Order Date: 2014-10-02
User: Angela DeLaRosa
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Ship Location: McLaren Bay Region Family Medicine/Attn Angela DeLaRosa
3720 Katalin Ct
Bay City, MI 48706
Forms
Quantity: 500
Paragon Dept No: 69000
Dept Name: McLaren Medical Group
Company Number: 810

Order Total Price: 0.00

Form Number: MM-113
Form Description: Consent for Office Procedure (Other than Routine Care)
Revision Date: 8/2013
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None

McLaren Ambulatory Care Center, McLaren Occupational Health/Convenient Care Center

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.

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 Signature Date/Time

_____
Physician Signature Date/Time

CONSENT FOR OFFICE PROCEDURE