

McLaren Print System Order

Order No: 8906 Reprint Previous Order No: 5594
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 3901 Highland Rd., Suite D
 Waterford, MI 48328

Forms
 Quantity: 100
 Paragon Dept No: 73650
 Dept Name: McLaren Oakland Waterford Family Med
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-113
 Item 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
 Misc Info:

McLaren Ambulatory Care Center, McLaren Occupational Health/Casualty 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 _____
 (if 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 OF 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

____ Operation sites verified/marked

____ Procedure verified

Physician Signature _____ Date/Time _____

Physician Signature _____ Date/Time _____

 Name

 Date/Time

041113 Rev 01/13 **CONSENT FOR OFFICE PROCEDURE**