McLaren Business Products

McLaren Print System Order

Order No: 42626 Reprint Previous Order No: 5594
Order Date: 2019-02-06
User: Katie Jacobs
Phone: 9898462600

Ship Location: Primary Care Rose City-Attn Beth Morris
2990 Campbell Rd PO Box 527
Rose City, Michigan 48661
Forms
Quantity: 500
Paragon Dept No: 69250
Dept Name: McLaren
Company Number: 811

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 ____________________ 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: ________ Date: ________
- Patient identified
- Operative site(s) verified/marked
- Procedure verified
- Skin Prep Dry Time Completed: ☐ Yes Ch/cs

Patient Physician

Patient Name

Date of Birth

CONSENT FOR OFFICE PROCEDURE