

**McLaren Print System Order**

**Order No: 50369 Reprint Previous Order No: 5594**  
**Order Date: 2019-11-19**  
**User: Kathy Warshefski**  
**Phone: 8109854300**

**Ship Location: ADVANCED ORTHOPEDICS**  
**1231 Pine Grove Avenue, Suite 1A**  
**Port Huron, MI 48060**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 66275**  
**Dept Name: MMG Port Huron**  
**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 \_\_\_\_\_ 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician: _____
Witness: _____

Physician: \_\_\_\_\_  
Witness: \_\_\_\_\_