McLaren Business Products

**McLaren Print System Order**

**Order No: 73707 Reprint Previous Order No: 5594**
**Order Date: 2022-11-16**
**User: Sheryl Weiler**
**Phone: 2489229975**

**Ship Location: McLaren Oakland Clarkston Internal Medicine**
**6507 TOWN CENTER DR SUITE A**
**CLARKSTON, Michigan 48346**
**Forms**
**Quantity: 100**
**Paragon Dept No: 73150**
**Dept Name: Mclaren Oakland Clarkston Internal Medicine**
**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: ☐ Yes ☐ n/a

_____ _____
Patient Physician

CONSENT FOR OFFICE PROCEDURE

Patient Name

Date of Birth