

McLaren Print System Order

Order No: 73890 Reprint Previous Order No: 15771
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User: MICHELLE GALATI
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Ship Location: McLaren Womens Health Chesterfield
51086 Fairchild Rd
Chesterfield, Michigan 48051

Forms

Quantity: 100
Paragon Dept No: 72000
Dept Name: McLaren Womens Health Chesterfield
Company Number: 260

Order Total Price: 0.00

Item Number: MO-113
Item Description: Consent for Office Procedure (Other than Routine Care)
Revision Date: 1/2016
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info:

McLaren Macomb
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. Some significant and substantial risk of this particular procedure includes \_\_\_\_\_

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 procedure Time out
Patient identified
Operative site(s) verified/marked
Procedure verified
Physician

Physician
Date of Birth