McLaren
THUMB REGION

REQUEST AND CONSENT FOR SURGICAL AND/OR INVASIVE PROCEDURES

IMPORTANT: Do not sign this form without reading and understanding the content.

I, ____ voluntarily consent to Dr. ____
(Patient's Name) (Doctor's Name)

and associates, and other health care providers, to perform the following surgical, medical, and/or diagnostic procedures (designate left/right where applicable):

____

____

If, during the course of the procedure described above, the doctor(s) authorized by this consent find it necessary or appropriate to perform additional and/or different procedures than those listed above, which are not known to be needed at the time consent is given; I consent to the performance of such procedures to treat my condition:

____
(Diagnosis)

I understand alternatives or refusal to the procedure(s) include worsening of medical condition, further injury, infection, bleeding, uncertain diagnosis, increased pain and/or death.

The surgical risk for this procedure include but are not limited to ____

____

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results or success of this procedure.

I consent to the examination, testing, and disposal of any tissue, organs, or limbs in accordance with the practice at McLaren Thumb Region. Diagnostic studies and examinations may be required to treat my condition. The release of my social security number to the manufacturer of any medical device implanted/explanted in accordance with Federal Law may be required. Students and/or technical sales representatives under the control of my physician may be present. Photographs and/or videotapes may become part of my medical record.

PATIENT ACKNOWLEDGMENT

By signing this form, I certify the following statements:

- I have read or had this form read and/or explained to me.
- I fully understand its contents.
- I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- Information was provided through direct conversation with my physician and/or other health care providers in terms/language that I understand.

Signature of patient/legal representative __________________________ Relationship ________________ Date ________ Time ________

Witness ____ Date _______________ Time _______________

PROVIDER ACKNOWLEDGMENT

By signing this form, I certify that I have explained to the patient or his/her representative:

- The diagnosis, nature, and purpose of the proposed operation, procedure, and/or treatment.
- The anticipated risks and benefits.
- The feasible alternatives and their risks and benefits.
- The patient's prognosis if the proposed treatment is not given.
- The probability/likelihood of successful outcome.

I have given the patient or his/her authorized representative the opportunity to ask questions, and believe all questions have been answered to the patient's satisfaction.

Signature of physician ____ Date _______________ Time _______________

Notes:

- For all patients 18 years or older who are competent, or all emancipated minor patients who are competent, this consent must be signed by the patient.
- For all minor patients who are not emancipated, this consent must be signed by: (1) a parent, if of age or emancipated; (2) by the patient advocate under the patient's advance directive, if applicable; or (3) by the patient's legal guardian. Where the minor patient is married; this consent may also be optionally signed by the patient and or the spouse.
- For all other patients who are incompetent, this consent must be signed by either a legal guardian or the patient advocate under the patient's advance directive, as is applicable.
- Consent in an emergency may be presumed by the physician, but the physician should justify the emergency and the presumption in the medical record.