McLaren Business Products

McLaren Print System Order

Order No: 83614 Reprint Previous Order No: 83609
Order Date: 2024-03-06
User: Andrea Miko
Phone: 586-493-1605

Ship Location: McLaren Macomb Surgical Services
1000 Harrington
Mt Clemens, MI 48043
Forms
Quantity: 1000
Paragon Dept No: 24485
Dept Name: Surgical Services
Company Number: 260

Order Total Price: 31.00

Item Number: 187120
Item Description: Surgical Consent
Revision Date: 09/2016
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: 8.5x11 Black SS

McLaren
MACOMB

CONSENT FOR: _____ DOB: _____
OPERATION / PROCEDURE / ANESTHESIA
BLOOD TRANSFUSION / TREATMENT

I (patient or guardian), hereby authorize: Dr. _____

_____

or his/ her designee, and such other physicians, medical residents, physicians in training, or other persons as are needed to assist him/her in perform:
Operation / Procedure/ Anesthesia/ Blood Transfusion /Treatment: _____

_____

I acknowledge that my physician/ anesthesiologist has explained to my satisfaction, in terms I understand, the reason for, the general nature of, the anticipated benefits of, the possible significant risks and complications of, and the significant alternatives to (including not performing), the proposed operation/ procedure/ treatment/ anesthesia.

Risks: The doctors have discussed the reasonably expected risks of the procedure, and I have been given enough information to permit informed consent. The more common risks include infection, bleeding (including severe blood loss requiring blood transfusion), nerve injury, blood clots, heart attack, allergic reactions, brain damage, liver damage, damage to the vocal cords, respiratory problems, damage to the teeth including temporary or permanent dental fixtures/ bonding, headache, minor pain and discomfort, blood pressure problems, and pneumonia. These are not all the possible risks associated with this procedure, but these and other risks can be serious and possibly fatal.

Some significant and substantial risks of this particular operation or procedure include: _____

_____

Additional Procedure(s): I understand my doctor(s) may find something they did not expect at the time of the surgery or procedure. I authorize him/ her to perform such treatments he/ she deems necessary.

Tissue Disposal: I consent to the examination by a pathologist, and disposal by hospital authorities of any tissue or body part that may be removed.

Photography: I consent to the taking and publication of any photographs in the course of the procedure for the purposes of advancing medical education and / or for permanent documentation in the medical record.

Blood Transfusion: I understand that in the event of severe blood loss, or decreased blood count, or a clotting problem, I may require a blood transfusion. I also understand that there are potential risks from blood transfusions, though rare. Some of these include transfusion reactions, hepatitis, and AIDS (Acquired Immune Deficiency Syndrome). I understand that the failure to transfuse when needed, could potentially cause additional medical problems, complicate existing ones, or lead to serious injury or death. The use of blood products has been explained to me, and I have had an opportunity to ask questions.

____ (Initials) I consent to receive blood or blood products. ____ (Initials) I DO NOT consent to receive blood or blood products.

NO GUARANTEE: I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees or assurances have been made as to the results of the operation or procedure, and it MAY NOT CURE THE CONDITION.

PATIENT CONSENT: I have read and fully understand the consent form. I fully understand everything the physician has explained to me. I understand that I can withdraw this consent at any time before the beginning of the procedure/ operation.

_____ _____ _____ _____
Patient / Patient Representative If Patient Representative – Relationship Date Time

PHYSICIAN DECLARATION: I have explained to the patient / patient's representative the procedure / operation and the risks, benefits, recuperation and alternatives (including the probable or likely consequences if no treatment is pursued). I have answered all of the patient's questions, and to the best of my knowledge, I believe the patient has been adequately informed.

Physician's Name _____

Time _____ Date _____ Physician's Signature _____