

McLaren Print System Order

Order No: 87208
Order Date: 2024-07-25
User: June Barrett
Phone: (586)493-8029

Ship Location: McLaren Macomb
1000 Harrington
Mount .Clemens, , Michigan 48043

Forms
Quantity: 100
Paragon Dept No: 24485-1175
Dept Name: Surgical Services
Company Number: 260

Order Total Price: 3.35

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
Poster:
Misc Info: 8.5x11 Black SS

McLaren MACOMB CONSENT FOR OPERATION / PROCEDURE / ANESTHESIA BLOOD TRANSFUSION / TREATMENT
I (patient or guardian), hereby authorize Dr. _____ as his/her designee, and such other physicians, medical residents, physicians in training, or other persons as are needed to assist him/her to 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, hair damage, damage to the vocal cords, respiratory problems, damage to the teeth including temporary or permanent dental fixture bonding, headache, minor pain and discomfort, blood pressure problems, and pneumonia. There 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 as she deems necessary.
Tissue Specimen: 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 receive a blood transfusion may result in death. I understand that I have the right to refuse a blood transfusion, or 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 I WANT CURE THE CONSENT.
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, expectations 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 _____
Date _____ Physician's Signature _____

Spec Info: First floor Sc. P.A.T 586-493-8029

