

McLaren Print System Order

Order No: 87242
Order Date: 2024-07-26
User: Farrah Garno
Phone: 810-342-4685

Ship Location: McLaren Flint-Radiology-2nd Floor-Attn: Farrah Garno
401 South Ballenger Hwy
Flint , MI 48532

Forms
Quantity: 500
Paragon Dept No: 27250-1075
Dept Name: Radiology
Company Number: 60

Order Total Price: 16.75

Item Number: 1761
Item Description: Consent to Operation or Other Procedure (McLaren Flint Region)
Revision Date: 05/2018
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Poster:
Misc Info:

McLaren Flint
Flint campus
CONSENT TO OPERATION OR OTHER PROCEDURE

1. I have been told by my physician, _____ that my present condition or conditions may effectively be treated by the following procedure(s): _____
I hereby authorize my physician and the associates and assistants selected by him to perform the described procedure(s).
2. I understand that unforeseen circumstances may arise during an operation or procedure, and may require performance of operations or procedures different from or in addition to those originally planned, in order to safeguard and promote the best being of the patient. I consent to such other or additional surgery procedures, or therapies as may be considered necessary or advisable by my doctors under such circumstances. I authorize and request that my physician, his assistants or his designees, perform such additional procedures as an necessary if at an outpatient facility, I consent to transfer to McLaren Flint main campus in the event that my condition warrants such a transfer.
3. I am aware that McLaren Flint is a resident teaching facility and that physician residents and/or medical students may be involved with my care under the supervision of my physician. I consent to their involvement and participation in my treatment planning and care.
4. I understand that such procedure(s) may involve transfusion of blood or blood cell products. I have been made aware that, despite routine screening procedures, use of blood and blood cell products always carries some risk of transmissible disease, including hepatitis virus, or other blood-borne agents. I give authorization to administer to me during the procedure(s):
[] regular blood or blood products from the Blood Bank;
[] autologous blood only (blood I have given); In the absence of the sufficient quantity of blood I have given, I understand regular blood or blood products from the Blood Bank will be used.
[] (designated (donor) donations only);
[] no blood products.
5. I agree to the use of anesthesia and/or sedation as deemed appropriate by the anesthesiologist or his/her designee. It has been explained to me that all forms of anesthesia involve some risks and although rare, unexpected severe complications may occur including but not limited to mouth or throat pain, injury to mouth or teeth, infection, injury to blood vessels, headache, backache and others. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia. I consent to the anesthesia service discussed with the anesthesia provider. I also consent to an alternative type of anesthesia if necessary as deemed appropriate by my anesthesia provider.
6. I acknowledge that full discussion has taken place between my physician and me prior to the procedure(s). Merits authorized, that the advantages and disadvantages of such procedure(s) including the risk of infection, have been explained to me, and that alternative methods of treatment have been discussed with me. I have been made aware of the risks and benefits of the procedure(s) and I understand that the practice of medicine and of surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

Spec Info: Radiology 2 north Flint Farrah Garno

Signature of Patient: _____ Date: _____ Time: _____
If patient is unable to sign or is a minor, complete the following
Signature of Next of Kin or Legal Guardian: _____ Date: _____ Time: _____
Signature Witnessed by: _____ Date: _____ Time: _____
I, Dr. _____, hereby attest to providing information regarding the patient's risk, including risk of infection, benefits, as well as alternative methods of treatment available to aid the patient and family in the decision process regarding the procedure(s).
Signature of Physician: _____ Date: _____ Time: _____
Anesthesia Provider Signature: _____ Date: _____ Time: _____

CONSENT TO OPERATION OR OTHER PROCEDURE



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