

McLaren Print System Order

Order No: 42643 Reprint Previous Order No: 15771
Order Date: 2019-02-06
User: Barbara Payne
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Ship Location: McLaren Macomb
1030 Harrington Blvd. Suite 206
Mount Clemens, MI 48043

Forms

Quantity: 100
Paragon Dept No: 60340
Dept Name: Center for Osteopathic Medicine
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 Name: _____
Date of Birth: _____