E. A. Hawse Health Center, Inc.
"Making A Difference"

P.O. Box 97
Baker, WV 26801
(304) 897-5915

PROCEDURE CONSENT FORM

NAME OF PATIENT: _____ DOB: _____ DATE: _____

CHART#: _____

TYPE OF PROCEDURE:

_____

_____

_____

TO BE PERFORMED BY OR UNDER THE DIRECTION OF: _____ ☐MD; ☐DO; ☐PA-C

ISSUES THAT HAVE BEEN DISCUSSED:

- Nature of the procedure and the reason for the procedure has been explained and advice about aftercare provided.
- The potential risk such as bleeding, bruising, infection, post injection pain, soft tissue atrophy, de-pigmentation of the skin, injury to nerves and vessels, joint damage, elevation of glucose level in diabetics.
- _____
  _____
  _____
  _____

☐ PATIENT ☐ PARENT/LEGAL GUARDIAN ☐ POWER OF ATTORNEY

I _____ (PRINT NAME) GIVE CONSENT TO THE PROCEDURE AS DESCRIBED BY THE ABOVE MENTIONED HEALTH CARE PROVIDER. I HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND UNDERSTAND FULLY THE REASONS FOR THE PROCEDURE.

PATIENT/GUARDIAN/POWER OF ATTORNEY

SIGNATURE: _____ DATE: _____ TIME: _____

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____

WITNESS SIGNATURE: _____ DATE: _____ TIME: _____