BERKSHIRE HEALTH SYSTEMS
GENERAL MEDICAL CONSENT

PLACE PATIENT LABEL HERE

PATIENT NAME _____ DATE OF BIRTH_____

AUTHORIZATION TO TREAT:

I (or the person acting on behalf of the patient listed above), do hereby authorize the rendering of such care, which may include routine diagnostic procedures and such medical treatment as deemed necessary by the physician or provider in charge of my care.

I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this facility.

I understand that:

1. It is customary, absent emergency or extraordinary circumstance, that no procedures performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or provider in charge of care to the patient's satisfaction; and
2. Each patient has the right to consent, or refuse to consent, to any proposed procedure or therapeutic course; and
3. On occasion, a physician or other provider may discover during the course of a consented to procedure that additional procedures or interventions may be necessary and I consent to such additional procedures or interventions.
4. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent.

_____ _____ _____ _____

(Date) (Time) (Patient/Legal Guardian/Health Care Agent) (Relationship, when applicable)

_____ _____ _____

(Date) (Time) (Witness)

____ Consent Not Obtained: Patient refuses treatment at this time

____ Consent Not Obtained: Patient is unable to sign this form due to severity of illness or is a minor and no patient representative was available to receive documents.

If Verbal consent is obtained, this requires a second witness signature:

Date: _____ Time: _____ Witness #2 Signature: _____

____ Verbal Consent Obtained: Due to patient condition, unable to physically sign form

____ Verbal Consent Obtained: Patient agrees to receiving above information, but refuses to sign form

==========

STATEMENT OF RECEIPT:

A copy of Patient Rights and Responsibilities, as per Massachusetts General Law, Chapter 111, Section 70E, will be available to me upon my request.

I have the right to file a complaint about my care and/or safety without fear of reprisal.

For all Patients 18 yrs or older, a copy of the Advance Directives User's Guide along with a Health Care Proxy form, will be made available upon request, which I may complete if I so desire.

For Inpatients and Observations Patients Only:Military Dependents, I have received a copy of the document titled Important Message from TRICARE.

SPECIAL PRIVACY PRACTICES: (Complete only for Inpatient or Observation Status)

1. I would like my name included in the Hospital Directory. (I understand the hospital will acknowledge my presence as a patient to anyone, including family and friends, who call or come to the Information Desk). Y N

2. I would like my name included in the Religious Listing. (I understand that my name will appear on printed lists provided to clergy sorted by Religion or Place of Worship.) Y N

3. I authorize notification to my Primary Care Provider of my admission before discharge. Y N

_____ _____ _____ _____

(Date) (Time) (Patient/Legal Guardian/Health Care Agent) (Relationship, when applicable)

MCON