

Tus neeg mob lub npe Patient name			
MHN MHN	Hnub yug DOB	Muaj tsawg xyoo Age	Poj niam los txiv neej Gender

Keu Kho Ib Tug Neeg Laus Uas Tsis Txawj thaum Tsis Muaj Tus Neeg Saib Xyuas Nyob Rau Ntawd**Daim Ntawv Tso Cai**

Nplooj 1 ntawm 2

Consent - Treatment of Adult Ward in Legal Guardian Absence

Page 1 of 2

Yuav kom ua tau raws li Wisconsin txoj cai, Marshfield Clinic Health System kom ib tug neeg saib xyuas raws txoj cai (tus neeg saib xyuas uas tsev txiav txim xaiiv) yuav tsum tso cai rau lub tsev kho mob uas tsev hais plaub xaiv los kho, nrog rau kev kho txoj kev feeb tsis mee. Yog thaum tus neeg saib xyuas raws txoj cai tso cai tsis tau rau txoj kev kho mob nws yuav xaiv tau ib tug neeg laus twg los tso cai rau los tau. Yog thaum lub tsev hais plaub tso cai ua kos npe rau, tej zaum yuav tsis pom zoo kho mob.

To comply with Wisconsin law, Marshfield Clinic Health System requires that a legal guardian (guardian appointed by a court) consent to the care of their court appointed ward, including mental health treatment. In the event that a legal guardian is unable to consent to the care, the legal guardian may delegate the right to consent to another adult. In the event that the ward presents for a non-urgent medical appointment without a legal guardian or a signed consent, treatment may be denied.

Kuv/Peb (tus neeg saib xyuas lub npe) _____ tso cai:
I/We (legal guardian's name) _____ authorize:

Tus neeg tso cai (Appointee – person authorized to consent) _____

Txheeb tus neeg mob li cas (Relationship to patient) _____

Tus neeg raug tsa tus xov tooj (Appointee's phone number) _____

Tus neeg raug tsa qhov chaw nyob (Appointee's address) _____

yog yuav tso cai – kos (✓) rau tag nrho cov uas raug:
to consent to – check (✓) all that apply:

Kev kho mob ceev los sis kho mob sai (nrog rau kev kho hlwb) nrog rau cov tsev kho mob hauv no thaum hu tsis tau kuv: Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. ntawm Rice Lake, thiab tag nrho cov tsev kho mob uas yuav los sis siv ua num rau ntawm pab pawg koom nrog Marshfield Clinic. Emergent or urgent care (including mental health treatment) at any of the following facilities when I cannot be reached: Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. of Rice Lake, all Marshfield Medical Center locations, and all facilities owned and/or operated by the aforementioned organizations.

Kev kho mob, kho kev puas hlwb los yog kho hniav – nrog rau kev txhaj tshuaj, kev soj ntsuam ntshav thiab lwm cov kev soj ntsuam seb yog mob dab tsi, tiam sis tsis muaj feem nrog rau kev phais los yog lwm yam uas yuav siv tshuaj nkaug kom tsaug zog (tsis yog cov tshuaj txhaj kom hloog) – txawm yog yuav nyob rau cov tsev kho mob twg muaj li nram no: Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. ntawm Rice Lake, tag nrho cov tsev kho mob uas koom nrog Marshfield Medical Center, thiab tag nrho cov tsev kho mob uas yuav los sis siv ua num rau ntawm pab pawg koom nrog Marshfield Clinic. Medical treatment, mental health treatment or dental care – including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia (except for a local anesthetic) – at any of the following facilities: Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. of Rice Lake, all Marshfield Medical Center locations, and all facilities owned and/or operated by the aforementioned organizations.

rau kuv qhov chaw kho mob (tus neeg mob lub npe) _____
for my ward (patient's name)

thaum lub sij hawm (tsis pub tshaj 1 xyoo):
during the period (not to exceed maximum of 1 year):

Hnub tim (hli/hnub/xyoo) _____ / _____ / _____ txog _____ / _____ / _____
Date (month/day/year) to

Tsis pub tshaj 1 xyoo
For a maximum period of 1 year

Keu Kho Ib Tug Neeg Laus Uas Tsis Txawj thaum Tsis Muaj Tus Neeg Saib Xyuas Nyob Rau Ntawd

Daim Ntawv Tso Cai (Txuas mus)

Nplooj 2 ntawm 2

Tus neeg mob lub npe <i>Patient name</i>	MHN <i>MHN</i>	Hnub yug <i>DOB</i>	Muaj tsawg xyoo <i>Age</i>	Poj niam los sis txiv neej <i>Gender</i>
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Kuv/peb (tus saib xyuas npe) _____
I/We (legal guardian's name)

tso caiv rau tus coj (tus mob npe) _____
authorize my ward (patient's name)

txais coj mus kuaj mob , rau lub caij tsis nrog niam nrog txiv
to receive routine care, unaccompanied during the period

(vas thib – hli/hnub/xyoo) ____ / ____ / ____ txog ____ / ____ / ____ (tsis pub dhaus li ntawm ib xyoo).
(date – month/day/year) to (not to exceed maximum of 1 year).

Neeg mob txais tau kev pab tiamsis kos tsis tau npe tso cai rau kev kuaj mob. Txhua yam tso cai yuav tsum yog kos npe los ntawm tus neeg muaj cai saib xyuas.
Patient may receive care but cannot sign consent for treatment. All consents must be signed by legal guardian.

Cov Kws Kho mob ntawm Marshfield Clinic, Inc., Family Health Center ntawm Marshfield, Inc., Lakeview Medical Center, Inc. ntawm Rice Lake, thiab tag nrho cov tsev kho mob uas yuav los sis siv ua num rau ntawm pab pawg koom nrog Marshfield Clinic yuav tsum tau sim hu rau kuv ua ntej yuav muab kev pab kho siv cov nab npawb xov tooj hauv no:
Providers at Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. of Rice Lake, all Marshfield Medical Center locations, and all facilities owned and/or operated by the aforementioned organizations should try to contact me before providing care using the following numbers:

Tus xov tooj hauv tsev _____ Tus xov tooj tom hauj lwm _____
Home phone Work phone

Tus xov tooj ntawm tes _____
Cell phone

Kuv nkag siab tias kuv qhov chaw kho mob yuav muaj txoj dej num los them rau cov nqi ntawm cov kev pab uas tau muab rau kuv txog qhov uas kuv qhov chaw kho mob qhov kev tuav pov hwm tsis kam them rau cov kev pab no. I understand that my ward will be responsible for the cost of services rendered to the extent that my ward's insurance does not pay for these services.

Tus neeg saib xyuas kos npe Legal guardian signature

Tus neeg saib xyuas qhov chaw nyob Legal guardian address

Kos npe hnub tim (hli/hnub/xyoo) Signature date (month/day/year)

Tus neeg saib xyuas tus xov tooj Legal guardian phone number

Puas muaj lam tus saib xyuas ntxhiv (If additional guardian):

Tus neeg saib xyuas kos npe Legal guardian signature

Tus neeg saib xyuas qhov chaw nyob Legal guardian address

Kos npe hnub tim (hli/hnub/xyoo) Signature date (month/day/year)

Tus neeg saib xyuas tus xov tooj Legal guardian phone number

Xa daim ntawv thov uas teb meej mus rau: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org
Send completed request to: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org