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

Kho Cov Menyuam Uas Tsis Tau Nto Hnub Nyoog Thaum Niam Txiv/Niam Qhuav Txiv Qhuav Uas Tau Kev Tso Cai Sawv Cev Raws Txoj Cai Tsis Nyob Rau Ntawd

Daim Ntawv Tso Cai

Consent – Treatment of Minors in Parent/Legal Guardian Absence

Qhov yuav kom ua raws li txoj kev cai lij choj hauv Wisconsin, Marshfield Clinic Health System xav kom tau niam txiv (tsis yog niam tshiab txiv tshiab/niam qhuav txiv qhuav) los sis ib tug neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj (tus neeg saib xyuas uas tsev hais plaub xaiv) los tso cai rau kev kho cov menyuam uas tsis tau nto hnub nyoog. Yog thaum uas niam txiv los sis tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj tso cai tsis tau rau kev kho mob, tus niam txiv los sis tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj yuav muab tau txoj cai los tso cai rau lwm tus neeg laus. Yog thaum uas ib tug menyuam tsis tau nto hnub nyoog tuaj rau lub sij hawm teem kho mob/kho kev nyuab siab/kho hniav uas tsis muaj leej niam leej txiv los yog tus niam qhuav txiv qhuav uas tau kev tso cai sawv cev raws txoj cai los yog daim ntawv tso cai uas kos npe tas rau lawm, tej zaum yuav tsis muab qhov kev pab kho.
To comply with Wisconsin law, Marshfield Clinic Health System requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to the care, the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical/mental health treatment/dental appointment without a parent or legal guardian or asigned consent, treatment may be denied.

☐ Kuv/Peb *(niam txiv/tus neeg tau cai saib xyuas npe)* _____ tso cai:
I/We (parent's/legal guardian's name) *authorize:*

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

Txheeb licas rau tus neeg mob *(Relationship to patient)* _____

Tus neeg tso cai qhov chaw nyob *(Appointee's address)* _____

Tus neeg tso cai tus xov tooj *(Appointee's phone number)* _____

tso cai rau – khij (✓) txhua qhov muaj:
to consent to – check (✓) all that apply:

☐ Kho mob maj nrawm lossis kho mob sai (nrog rau kev kho mob hlwb) ntawm Marshfield Clinic Health System thiab cov chaw koom tes thaum hu tsis tau kuv
Emergent or urgent care (including mental health treatment) at Marshfield Clinic Health System and affiliates when I cannot be reached

☐ Kev kho mob, kev kho mob hlwb lossis kho hniav – nrog rau xav tshuaj, kuaj ntshav thiab lwm yam kev kuaj, tiamsis tsis nrog tej kev phais lossis lwm yam kev kho uas siv tshuaj loog (tsuas yog nrog cov tshuaj loog kiag cheeb tsam kho) – ntawm Marshfield Clinic Health System thiab cov chaw koom tes
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 Marshfield Clinic Health System and affiliates

☐ Tag nrho txhua yam kev kho mob/kho kev nyuab siab/kho hniav uas tsim nyog thiab kev phais thiab kev kho mob hauv Marshfield Clinic Health System
Any and all necessary medical/mental health treatment/dental and surgical care and treatment at Marshfield Clinic Health System

Kho Cov Menyuam Uas Tsis Tau Nto Hnub Nyoog Thaum Niam Txiv/Niam Qhuav Txiv Qhuav Uas Tau Kev Tso Cai Sawv Cev Raws Txoj Cai Tsis Nyob Rau Ntawd

Daim Ntawv Tso Cai (Txuas mus)

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

rau kuv tus menyuam (tus neeg mob lub npe)_____
thaum lub sij hawm (tsis txhob pub tshaj li 1 xyoo):
for my child (patient's name) during the period (not to exceed maximum of 1 year):

☐ Hnub tim *(hli/hnub/xyoo)* _____ /_____ /_____ rau _____ /_____ /_____
Date (month/day/year) to (month/day/year)

☐ Kom txwm nkaus 1 xyoos *(For a maximum period of 1 year)*

☐ Kuv/Peb *(niam txiv/tus tau cai tu lub npe)* _____ tso cai kuv tus menyuam muaj hnub nyoog tsav tsheb (neeg mob lub npe) _____ tuaj kuaj tau kev mob nkeeg, nws tus kheej ib leeg rau lub sijhawm (hnub – hli/hnub/xyoo) _____ /_____ /_____ rau _____ /_____ /_____
I/We (parent's/legal guardian's name) authorize my driving-age child (patient's name) to receive routine care, unaccompanied during the period (date – month/day/year) to (date – month/day/year)

☐ Kuv/Peb *(niam txiv/tus tau cai tu lub npe)* _____ tso cai kuv tus menyuam (neeg mob lub npe) _____ tuaj goj ib ce/xyaum ua dej num, nws tus kheej ib leeg rau lub sijhawm (hnub – hli/hnub/xyoo) _____ /_____ /_____ rau _____ /_____ /_____
I/We (parent's/legal guardian's name) authorize my child (patient's name) to attend physical/occupational therapy appointments unaccompanied during the period (date – month/day/year) to (date – month/day/year)

☐ Kws kho mob ntawm Marshfield Clinic Health System thiab cov chaw koom tes yuav tsum sim hu rau kuv ua ntej muab kev pab siv cov xov tooj uas muaj raws li nram no:
Providers at Marshfield Clinic Health System and affiliates should try to contact me before providing care using the following numbers:

Xov tooj hauv tsev *(Home phone)* _____

Xov tooj tom hauj lwm *(Work phone)* _____

Xov tooj ntawm cev *(Cell phone)* _____

Kuv pom zoo mus ntxiv yuav them tej nuj nqes rau Marshfield Clinic Health System tus neeg muab kev pab kho mob rau cov nqi kho mob yog hais tias cov menyuam lub qhov chaw them nqi kho mob tsis them rau cov nuj nqes no.
I further agree to reimburse Marshfield Clinic Health System health care provider for the cost of rendering these services to the extent that the minor's insurance does not pay for these services.

_____ _____
Tus me nyuam niam txiv/tus neeg saib xyuas kos npe
Child's parent/legal guardian signature

Kev sib txheeb rau tus neeg
Relationship to patient

_____ _____ _____ /_____ /_____
Tus menyuam niam thiab txiv/tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj qhov chaw nyob
Child's parent/legal guardian address

Niam txiv/Tus neeg tau cai saib xyuas xov tooj
Parent/Legal guardian phone number

Kos npe hnub tim (hli/hnub/xyoo)
Signature date (m/d/y)

Xa daim ntawv thov uas teb meej mus rau: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consents@marshfieldclinic.org
Send completed form to: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consents@marshfieldclinic.org

