Marshfield Clinic Health System

Patient Name:	MHN:	DOB:	Sex:

Consent Treatment of Adult Ward in Legal Guardian Absence

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.

❑ I/We (legal guardian's name) _____ authorize:

Appointee (person authorized to consent) _____

Relationship to patient _____ Appointee's phone number - - _____

Appointee's address _____

to consent to – check all that apply:

❑ Emergent or urgent care (including mental health treatment) at Marshfield Clinic Health System and affiliates

❑ 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

for my ward (patient's name) _____

during the period (not to exceed maximum of 1 year):

❑ Date (month/day/year) _____/ / _____ to _____/ / _____

❑ For a maximum period of 1 year

❑ I/We (legal guardian's name) _____ authorize my ward:

(patient's name) _____ to receive routine care, unaccompanied during the period

(date – month/day/year) _____/ / _____ to _____/ / _____ (not to exceed maximum of 1 year).

Patient may receive care but cannot sign consent for treatment. All consents must be signed by legal guardian.

❑ Providers at Marshfield Clinic Health System and affiliates should try to contact me before providing care using the following numbers:

Home phone - - _____ Work phone - - _____ Cell phone - - _____

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.

_____ _____

Legal guardian signature and date & time | Legal guardian address

_____ _____

If additional guardian, legal guardian signature and date & time | Legal guardian address

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

See next page for Telephone Consent documentation.

Patient Name:	MHN:	DOB:	Sex:

☐ **Telephone consent** ***(or verbal consent to include those physically unable to sign)***

Today's date (month/day/year) / / Time _____ Telephone - - _____

Name of person authorizing _____ Relationship _____

Reason for telephone consent _____

❑ Person authorized treatment/procedure ❑ Person **DID NOT** authorize treatment/procedure

_____ _____
Witness signature and date & time PRINT witness name

_____ _____
Second witness signature and date & time PRINT witness name

