| Patient name | | | |
|---|---|---|---|
| MHN | DOB | Age | Gender |

**Treatment of Adult Ward in Legal Guardian Absence**

# Consent



To comply with Wisconsin law, Marshfield Clinic 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 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 *(guardian's name)* _____ authorize

Appointee's name _____

Relationship _____

Appointee's address _____

Appointee's phone number _____

to consent to:

☐ Emergent or urgent care at Marshfield Clinic when I cannot be reached to include mental health treatment.

☐ Medical, mental health treatment and dental care at Marshfield Clinic including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia, except for a local anesthetic.

☐ Any and all necessary medical/mental health treatment/dental and surgical care and treatment at Marshfield Clinic.

for my ward:

Patient's name _____ Patient's MHN _____

during the period:

☐ Date *(month/day/year)* _____ /_____ /_____ to _____ /_____ /_____

☐ For a maximum period of 1 year

☐ Marshfield Clinic providers should attempt to contact me before providing care at the following numbers:

Home phone _____ Work phone _____ Cell phone_____

**I further agree to reimburse Marshfield Clinic/health care provider for the cost of rendering these services to the extent that my ward's insurance does not pay for these services.**

_____ ____/____/____

Legal guardian signature Date (month/day/year)

_____

Legal guardian address

 © 2008 Marshfield Clinic 