ORANGE REGIONAL MEDICAL CENTER

Informed Consent for Infusion Center Treatment

Bassett, William J
Sex:M DOB:4/1/1944 75 y.o.
MRN:157380 DOS:1/08/20
Acct: 5001518039
CSN: 12828502

I hereby give my consent and authorize: Dr. Carey and those who he/she may designate as associates or assistants and Orange Regional Medical Center (Hospital) and its staff to perform the following

treatment upon: William Bassett
(Patient's name).

(Describe the treatment in both clinical and laymen's terms. No Acronyms or Abbreviations):

IV access, IV medication administration

I give permission with full knowledge and understanding thereof. I understand that medicine is not an exact science and that there is the possibility that the treatment may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with the, use of medication, and treatments which can cause adverse consequences not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the treatment(s) specified above.

(Date)	(Time)	(Patient/Health Care Agent/Surrogate/Guardian Signature)	(Printed Name)	(Relationship to Patient)
01/08/20	1415 AM/PM	William Bassett	William Bassett	

(Date)	(Time)	(Witness Signature)	(Printed Name)
01/08/20	1415 AM/PM		ROSALINDA YAP

☐ Mark this box if interpreter was involved. _____ (Interpreter ID #)

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the treatment(s), the alternatives, including not performing the treatment(s), as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

MD
(Signature of Physician/Appropriately Credentialed Practitioner Providing Explanation)