**Medical Consent Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NA \_\_\_

Rendering Medical Provider Names: Wound and Medical Outreach Clinic, LLC, rendering provider, Jill Marshall-Allen APRN CWS FL APRN 1692262 NPI 1205877560

*Consent for Medical Services Provided by Wound and Medical Outreach Clinic*

I, or my legal representative as listed above, request and authorize medical care as my physician and/or designated licensed medical provider (collectively called the “providers”) as deemed necessary or advisable. This care may include, but is not limited to, physical examination, routine diagnostics, radiology and laboratory procedures, prescribing and administrations of routine drugs, biological and other therapeutics, minor outpatient procedures, consult/referral for additional health providers/services, and routine medical and nursing care as authorized under current statute of State of Florida Board of Medicine and Board of Nursing. I authorize my “providers” to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health as delineated in my advanced care directives. I understand that my (the patient) care is directed by my “providers”, may be subject to revision by my other outside providers if requested by myself or Primary Care Provider, and that other personnel, such as home health agency staff, that render care and services to me may be acting on the “providers” written instructions. I acknowledge the “providers” have attained National Board Certification as a Certified Wound Specialist and Licensure by the State of Florida to legally perform procedures below:

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| Initial  For consent | Procedure | Description | Risks/Benefit includes but not limited to---- |
|  | Suture | “Stitches” for minor laceration/skin tears, area numbed by topical/local anesthesia | Risks-Anesthesia stings/pain, infection, bruising, bleeding, infection  Benefits-stabilizes wounds, allows healing, less risk for recurrent/further injury, decreased risk bleeding |
|  | Incision & Drainage | Draining of Infected Abscess by numbing area with topical/local anesthesia, making small incision to allow infection to drain, may require gentle packing | Risk- Anesthesia stings/pain. Abscess may be tender to touch, bruising, bleeding, infection  Benefit-May heal infection without additional treatment depending on size and surrounding infection, resolves abscess |
|  | Conservative Wound Debridement | Applying spray topical anesthetic to numb the area, removing infected, or necrotic (“dead”) tissue from wound with forceps, scalpel or curette. | Risk-Spray topical may briefly sting, bleeding, infection, “achy” afterwards, may find underlying abscess.  Benefit-Allows healthy tissue to grow and fill wound, may be used to prevent wound for getting worse if unable to grow new tissue, controls infection, odor and pain when infected or necrotic tissue removed. |
|  | Biopsy | Applying topical or local anesthesia to numb area, remove lesion or fingernail size of tissue to identify cause (skin cancer, rash, infection) by shaving ex derma blade, scalpel or punch technique. | Risk- Anesthesia stings/pain, infection, bruising, bleeding, infection, discomfort afterwards.  Benefit-Removal/destruction of abnormal lesions, obtain laboratory identification of problem. |

I, or my legal representative, acknowledge we may halt any procedure at any time and that in doing so may experience failure to achieve health goals or have a suboptimal outcome.

I, or my legal representative, understand that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the result of the above procedure.

I, or my legal representative, acknowledges they have received a copy of post-procedure instructions and have had all questions and concerns answered.

I, or my legal representative, acknowledges inability or failure to follow post-procedure instructions may result in suboptimal outcomes, failure to achieve health goals and serious complications beyond the control of the rendering provider.

I, or my legal representative, acknowledges we have been advised to check procedure site frequently and notify the Provider any swelling, redness, worsening pain, discharge, bleeding, fever or unexplained changes in blood sugar immediately, or my legal representative, acknowledges they have been advised to call 911 for any acute, frightening or unexplained changes in overall condition following any procedure.

I, or my legal representative, consent to photography of the affected area only and random review of progress note/procedure note by supervising Medical Director for quality assurance evaluation and medical documentation.

I OR MY LEGAL REPRESENTATIVE, HAVE READ OR HAD READ TO ME AND FULL UNDERSTAND THIS CONSENT; I OR MY LEGAL REPRESENTATIVE, HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED; I OR MY LEGAL REPRESENTATIVE, UNDERSTAND CONSENT MAY BE WITHDRAWN AT ANY TIME BY DIRECTLY NOTIFYING THE PROVIDER.

Signature of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable; Signature of Legal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Consent for Signature by Caregiver/Staff-please complete info above regarding representative:

#1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone witness please print names and contact info:

Signature of Reviewing Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_