VAN WERT COUNTY HOSPITAL

ADVANCE AUTHORIZATON FOR MEDICAL AND/OR SURGICAL TREATMENT

On behalf of ____

(Name of future patient on whose behalf this consent is completed)

Recognizing that the above designated person may require hospital or emergency care do hereby voluntarily consent to such hospital or emergency care encompassing diagnostic procedures or medical and/or surgical treatment by a doctor, his assistants, or his designees as is necessary in his judgment. I understand the doctor will be a member of the medical staff of Van Wert County Hospital. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of diagnostic procedures or medical and/or surgical treatment in the hospital. I hereby consent to the administration of such anesthetics as may be considered necessary or advisable as a result of diagnostic procedures or medical and/or surgical treatment.

I hereby authorize the Van Wert County Hospital to preserve for scientific or teaching purposes: or otherwise dispose of any dismembered tissue, parts, or organs resulting from diagnostic procedures, or medical treatment and/or surgical treatment as the patient may receive.

I hereby request that such of the above consents be deleted as I have specified immediately below:

____

(Specify with particularity sections which patient (legal guardian) requests be deleted.)

____

____

I have read this form and certify that I understand its contents.
I authorize this consent to remain valid for:____

(State month and year you wish this consent to expire.)

Signed:________________________________

(Signature of person signing for future patient)

Date______________________________Relationship_____________________________

(Relationship to future patient)

Witness____________________________ Future Patient___________________________

(Name of future patient on whose behalf this consent is completed.)

Witness____________________________ Age of Future Patient______________________

(State age of future patient only if patient is presently under age 21.)

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize Van Wert County Hospital Association to furnish information from my medical records pertaining to this hospitalization as requested by either group hospital insurance plans or companies or Industrial Commission of Ohio if applicable to this case.

Signed: ____

MEDICAL INFORMATION SHEET

Efforts will be made to contact parents or guardian in the event a child is brought to the Van Wert County Hospital Emergency Department.

1. Emergency Notification:

   Parent or Guardian _______________________________ Home Phone #___________________

   Home Address___________________________________ Work Phone # ___________________

   If not able to contact Parents or Guardian:

   Close relative or friend ____________________________ Phone # ________________________

2. Minor's full name ________________________________ Nick Name______________________

   Minor's Birth Date ____

3. Family Doctor __________________________________ Dentist __________________________

   Preferred Surgeon ____

4. History of Allergies ____

5. Medications taken routinely at home ____

   ____

6. Date of last tetanus immunization ____

7. Chronic illnesses or birth defects ____

   ____

8. Special instructions or comments ____

   ____

Please notify the Emergency Room staff at 419-238-8611 if:

1. You want the consent form removed from the files.
2. Any changes or additions to the above information.