

Tus neeg mob lub npe Patient name			
MHN MHN	Hnub yug DOB	Muaj tsawg xyoo Age	Poj niam los txiv neej Gender

**Keu Kho Ib Tug Neeg Laus Uas Tsis Txawj thaum Tsis Muaj Tus Neeg Saib Xyuas Nyob Rau Ntawd****Daim Ntawv Tso Cai**

Nplooj 1 ntawm 2

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

Page 1 of 2

Yuav kom ua tau raws li Wisconsin txoj cai, Marshfield Clinic/Family Health Center kom ib tug neeg saib xyuas raws txoj cai (tsev hais plaub ua tus nrhiv tus neeg saib xyuas no) yuav tsum tso cai rau lub tsev kho mob uas tsev hais plaub xaiv los kho, nrog rau kev kho txoj kev feeb tsis meej. Yog thaum tus neeg saib xyuas raws txoj cai tso cai tsis tau rau txoj kev kho mob nws yuav xaiv tau ib tug neeg laus twg los tso cai rau los tau. Yog thaum lub tsev hais plaub tuaj kho mob rau ib qho uas tsis yog muaj xwm ceev uas tsis muaj tus neeg saib xyuas nyob rau ntawd los sis daim ntawv tso cai uas kos npe rau, tej zaum yuav tsis pom zoo kho mob.

*To comply with Wisconsin law, Marshfield Clinic/Family Health Center 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.*

Kuv/Peb (tus neeg saib xyuas lub npe) \_\_\_\_\_ tso cai  
I/We (guardian's name/s) \_\_\_\_\_ authorize

Tus neeg tso cai \_\_\_\_\_  
Appointee (person authorized to consent)

Txheeb tus neeg mob li cas \_\_\_\_\_  
Relationship to patient

Tus neeg raug tsa qhov chaw nyob \_\_\_\_\_  
Appointee's address

Tus neeg raug tsa tus xov tooj \_\_\_\_\_  
Appointee's phone number

yog yuav tso cai – kos (✓) rau tag nrho cov uas raug:  
to consent to – check (✓) all that apply:

- Kev kho mob ceev los sis kho mob sai ntawm Marshfield Clinic/Family Health Center thaum hu tsis tau kuv uas suav cov kev kho txog kev puas hlwb tib si thiab.  
*Emergent or urgent care at Marshfield Clinic/Family Health Center when I cannot be reached to include mental health treatment.*
- Kev kho mob, kho kev puas hlwb thiab kho hniav ntawm Marshfield Clinic/Family Health Center mas muaj xws li kev txhaj tshuaj, kev soj ntsuam roj ntsha thiab lwm cov kev ntsuam xyuas seb yog mob dab tsi, tiam sis tsis suav cov kev phais los sis lwm cov kev ua yav dhau los uas yuav tsum tau tso tshuaj, tshwj tsis yog cov tshuaj txhaj kom loog rau tib qho chaw xwb.  
*Medical, mental health treatment and dental care at Marshfield Clinic/Family Health Center including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia, except for a local anesthetic.*

rau kuv qhov chaw kho mob:  
for my ward:

Tus neeg mob lub npe \_\_\_\_\_  
Patient's name

**Kev Kho Ib Tug Neeg Laus Uas Tsis Txawj thaum Tsis Muaj Tus Neeg Saib Xyuas Nyob Rau Ntawd**

**Daim Ntawv Tso Cai (Txuas mus)**

Nplooj 2 ntawm 2

Tus neeg mob lub npe <i>Patient name</i>	MHN <i>MHN</i>	Hnub yug <i>DOB</i>	Muaj tsawg xyoo <i>Age</i>	Poj niam los sis txiv neej <i>Gender</i>
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thaum lub sij hawm (tsis pub tshaj 1 xyoos):  
*during the period (not to exceed maximum of 1 year):*

Hnub tim (hli/hnub/xyoo) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ txog \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Date (month/day/year) to*

Tsis pub tshaj 1 xyoos  
*For a maximum period of 1 year*

Marshfield Clinic/Family Health Center cov neeg muab kev pab yuav tsum tau sim hu rau kuv ua ntej muab kev pab kho ntawm cov xov tooj nram qab no:  
*Marshfield Clinic/Family Health Center providers should attempt to contact me before providing care at the following numbers:*

Tus xov tooj hauv tsev \_\_\_\_\_ Tus xov tooj tom hauj lwm \_\_\_\_\_  
*Home phone Work phone*

Tus xov tooj ntawm tes \_\_\_\_\_  
*Cell phone*

**Kuv nkag siab tias kuv qhov chaw kho mob yuav muaj txoj dej num los them rau cov nqi ntawm cov kev pab uas tau muab rau kuv txog qhov uas kuv qhov chaw kho mob qhov kev tuav pov hwm tsis kam them rau cov kev pab no.**  
***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.***

\_\_\_\_\_  
*Tus neeg saib xyuas kos npe  
Legal guardian signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Kos npe hnub tim (hli/hnub/xyoo)  
Signature date (month/day/year)*

\_\_\_\_\_  
*Tus neeg saib xyuas qhov chaw nyob  
Legal guardian address*

\_\_\_\_\_  
*Tus neeg saib xyuas tus xov tooj  
Legal guardian phone number*

**Puas muaj lam tus saib xyuas ntxhiv (If additional guardian):**

\_\_\_\_\_  
*Tus neeg saib xyuas kos npe  
Legal guardian signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Kos npe hnub tim (hli/hnub/xyoo)  
Signature date (month/day/year)*

\_\_\_\_\_  
*Tus neeg saib xyuas qhov chaw nyob  
Legal guardian address*

\_\_\_\_\_  
*Tus neeg saib xyuas tus xov tooj  
Legal guardian phone number*

**Xa daim ntawv thov uas teb meej mus rau: Release of Medical Information, Marshfield Clinic, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org**

**Send completed form to: Release of Medical Information, Marshfield Clinic, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org**