Patient Name

DOB:

MR #:

UW Health **www.uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)
CONSENT TO OPERATIONS FOR PEDIATRIC TRANSPORTATION AND TREATMENT

Date: _____

_____ _____
Patient's Name (Last, First, Middle Initial) Date of Birth

_____ _____
Parent(s)/Guardian(s) Name Telephone

_____ _____
Home Address: Street City/Town State Zip code

Consent for Transportation and Treatment

I understand that clinicians at _____ Hospital have recommended that my child/ward be transferred to _____ for treatment of the following conditions:

_____

_____

I authorize transportation of my child/ward to _____. I understand that the operation of ambulance services is the responsibility of an independent company contracted by the University of Wisconsin Hospitals and Clinics.

I authorize staff from the University of Wisconsin Hospitals and Clinics to provide any treatment (e.g. administration of medications, anesthesia, blood products etc.) as may be deemed clinically necessary during the transportation of my child/ward to _____. I understand that there may be risks related to such treatment, which vary depending on the patient's condition, the treatment provided, and other factors.

_____ _____ _____
Signature of Parent/Guardian Date Time

Refusal for Transportation and Treatment

I understand that clinicians at _____ Hospital have evaluated my child/ward's medical condition and have recommended that my child/ward be transported to _____ for further care. The risks and benefits of a transfer of care to _____ have been explained to me. Despite such recommendations and discussions, I refuse to have my child/ward be transported to _____ or cared for by University of Wisconsin Hospitals and Clinics' staff.

_____ _____ _____
Signature of Parent/Guardian Date Time

_____ _____ _____ _____
Signature of UWHC Staff Date Time Pager