Hospital Treatment Guardianship Consent Form

Patient Information

Full Name

Date of Birth

Patient ID / MRN

Address

Guardian Information

Guardian Name

Relationship to Patient

Contact Number

Address

Legal Authority (type of guardianship)

Treatment Information

Treatment/Procedure Description

Doctor / Provider Name

Consent

I, as the lawful guardian of the above-named patient, hereby consent to the medical treatment/procedure as

described above. I have had the opportunity to ask questions and understand the information provided by the medical team.

Guardian Signature

Date

Witness Name

Witness Signature

Date