St. Mary's Healthcare
Amsterdam

Patient info

Consent for Infusion

St Mary's Healthcare
Infusion Center
4950 State Highway 30, 1st Floor
Amsterdam, NY 12010
Phone-518-770-7557 Fax-518-841-3671

I authorize Dr. ____________________________ and staff at the St Mary's Infusion Center to administer treatment consisting of: ____ to me for the diagnosis of: ____________________________________. In addition, I consent to receive other medications.

Dr. ____________________________ has explained to me the purpose of the treatment, including the potential benefits and complications, the attendant risks and side-effects, the alternatives to treatment, including the option of no treatment.

I have been given the opportunity to ask questions of my Provider, and all of my questions have been answered to my satisfaction. I do not request, nor require any further explanation at this time. I acknowledge that no guarantees have been made concerning the results of the treatment. I understand that during the treatment, unforeseen conditions may arise which could require additional procedures. I consent to such procedures as deemed necessary by Dr. ______________________________ or those individuals acting on her/his behalf and at his/her direction.

I confirm that I have read and fully understand this consent form and any educational materials provided to me.

Signature of Patient/Relative/Guardian: _________________________

Name Printed: ________________________________ Relationship: ______________________

Interpreter (if needed):_______________________________________

Name Printed: ________________________________ Relationship: ______________________

I certify that I have explained the nature, purpose of, potential benefits and risks of, as well as the alternatives to the proposed course of treatment, and have offered to answer any and all questions pertaining to the treatment. I believe the patient/parent/guardian who signed above understands what I have explained and answered.

Physician's Signature: __________________________________ Time: _____________Date: __________

Revised HIM/TB 02/07/24