OKLAHOMA DEPARTMENT OF CORRECTIONS
CONSENT FOR MEDICAL AND MENTAL HEALTH TREATMENT

Facility: ___________________________ Date: ___________ Time: ___________

I hereby authorize ___________________________ and assistants to perform
(Name of Provider)
the following operation, procedure or treatment:

________________________________________________________________________

The nature and the extent of the intended operation, procedure or treatment have been
explained to me in detail.

I have been advised by the above provider of the following alternatives, if any, probable
consequences if I remain untreated, risks and possible complications of proposed
treatment as indicated:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I acknowledge that no guarantee or assurance has been made as to the desired result
that may be obtained.

If any unforeseen condition arises in the course of the operation, procedure or treatment
calling for the judgement of the provider for procedures in addition to or different from
those now contemplated, I further request and authorize the provider to do whatever is
deeded necessary.

I consent to the administration of anesthesia to be applied by or under the direction of the
above named practitioner or his designee, and the use of anesthetics, as he/she may
deem advisable.

Please check one of the boxes below, which describes your situation:

☐ I have read and fully understand the terms of this consent and acknowledge that the
  explanations referred to were made and that all blanks have been filled.
  OR

☐ I do not speak or read English and an interpreter has explained this consent to me.
  I fully understand the terms of this consent and acknowledge that the explanations
  referred to were made and all blanks have been filled.

  Name of Interpreter: ___________________________

Inmate Signature: ___________________________________________ Date: __________

Health Care Provider: _________________________________________ Date: __________

Inmate Name (Last, First)  ODOC Number

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