CONSENT FOR VOLUNTARY INPATIENT TREATMENT

NAME OF PATIENT	LAST	FIRST	MIDDLE	AGE	SEX

NAME OF COUNTY PROGRAM	NAME OF BASE SERVICE UNIT	BASE SERVICE UNIT NUMBER
NAME OF FACILITY	ADMISSIONS DATE	ADMISSIONS NUMBER

INSTRUCTIONS

BEFORE SIGNING THIS FORM, YOUR TREATMENT SHOULD BE EXPLAINED TO YOU AND YOU MUST BE GIVEN A COPY OF THE PATIENT'S BILL OF RIGHTS. THE REPORT OF YOUR INITIAL EVALUATION AND THE PROPOSED TREATMENT PLAN MUST BE COMPLETED AND SIGNED BY YOU AND THE PHYSICIAN.

VOLUNTARY CONSENT TO INPATIENT TREATMENT

For the above-named person who is: ☐ an adult 18 years of age or older or

☐ a person who is at least 14 years of age and not yet 18 years old

I consent to the treatment which has been explained to me including the types of medication, examination procedures and the types of restrictions which are applicable; and

I understand that in order to leave before I am discharged, I must give _____ hours advance notice in writing to those in charge of my treatment; and
(UP TO 72)

I confirm that my rights and responsibilities while a patient in this hospital have been explained to me.

_____ SIGNATURE OF PATIENT

_____ DATE OF SIGNATURE

For the above-named person who is: ☐ under 14 years of age

I consent to the treatment of my child or ward which has been explained to me including the types of medication, examination procedures and the types of restrictions which are applicable; and

I understand that in order to take my child or ward out of the hospital before he or she is discharged, I must give _____ hours advance notice in writing to those in charge of the patient's treatment; and
(UP TO 72)

I confirm that the rights and responsibilities for myself and my child or ward while a patient in this hospital have been explained to me.

_____ SIGNATURE OF:

_____ DATE OF SIGNATURE

☐ PARENT OR

☐ GUARDIAN

_____ PRINT NAME OF PERSON SIGNING ABOVE

INITIAL EVALUATION AND TREATMENT PLAN

INITIAL FINDINGS:

DESCRIPTION OF PROPOSED TREATMENT PLAN:

DESCRIPTION OF PROPOSED RESTRICTIONS AND RESTRAINTS:

SIGNATURE OF PHYSICIAN/DATE

SIGNATURE OF CLIENT/PARENT/OR GUARDIAN/DATE

Any person who knowingly provides any false information when he/she completes this form may be subject to prosecution.