

## Psychiatric Services Consent

<b>Child Name:</b>			<b>Today's Date:</b>
<b>Child's Foster/Substitute Care Provider:</b>			Phone:
			Cell:
<b>Address</b>	Street:	City / State	Zip Code:
<b>Person Legally Responsible for the Psychiatric Care of the Child:</b>			Phone:
			Cell:
<b>Address</b>	Street:	City / State	Zip Code:

### SERVICE REQUEST

<b>Psychiatric Professional:</b>		<b>Service Date:</b>
Phone:	Service Location Name & Address:	<b>Service Time:</b>
<b>Type of Service to be Provided and Purpose:</b>		
Routine Visits Requested:    Yes    No		If Yes, Frequency of Visits and Length of Treatment:

If I, as the person legally responsible for the psychiatric care of the child, am unable to attend a visit, I am available to discuss the visit and the treatment recommended for the child with the psychiatric professional named above. I can be reached at the phone listed above.

I hereby give my consent for the above psychiatric treatment:

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**Signature** (Person legally responsible for the psychiatric care of the child) **Date**

I additionally authorize routine visits at the frequency and length of treatment as written above:

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**Signature** (Person legally responsible for the psychiatric care of the child) **Date**

I hereby **DENY** the above psychiatric treatment:

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**Signature** (Person legally responsible for the psychiatric care of the child) **Date**

Distribution: Copy to Child Welfare Agency and Child's Substitute Care Provider