STATE OF NEVADA

Division of Child and Family Services

Children’s Mental Health Programs

INFORMED CONSENT TO TREATMENT

Consent for Evaluation and Treatment of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Full Name of Client)

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Record #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I acknowledge that I have been informed that my child is in need of mental health services and treatment which includes: (check all that apply)

[ ]  Psychiatric Services, including medication administration and management

[ ]  Psychotherapy services, including early childhood services or outpatient services or concurrent psychotherapy services with residential services

[ ]  Day Treatment Services

[ ]  Residential Services (i.e., treatment home placement, RTC, or acute hospitalization)

[ ]  Targeted Case Management

[ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I acknowledge that I have been provided complete and accurate information with regard to these above noted services, including:
	1. The outcome of the evaluation and the benefits of the proposed treatment
	2. Alternative treatment modes and services
	3. The manner in which treatment will be administered
	4. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
	5. Probable consequences of not receiving treatment
2. Right to Withdraw Consent: I acknowledge I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating DCFS mental health professional.
	1. Expiration of Consent: I understand this informed consent will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I hereby provide my informed consent for the evaluation and treatment of my child. I also attest that I am the legally responsible person for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of child) and I have the right to consent for the evaluation and treatment of this child. I understand that I have the right to ask questions of my child’s assigned mental health professional or any other member of my child’s treatment team about the above information at any time.

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Signature of Legally Responsible Person Date

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Signature of DCFS Witness Date