Psychiatric Services Consent

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

SERVICE REQUEST

Psychiatric Professional:		Service Date:
Phone:	Service Location Name & Address:	Service Time:
Type of Service to be Provided and Purpose:		
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:

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:

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

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

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

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