CONSENT FOR VOLUNTARY INPATIENT TREATMENT

NAME OF PATIENT | LAST | FIRST | MIDDLE | AGE | SEX
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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

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

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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

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.

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SIGNATURE OF: ___________________________ DATE OF SIGNATURE ___________________________

- [ ] PARENT OR
- [ ] GUARDIAN

PRINT NAME OF PERSON SIGNING ABOVE ___________________________

PAGE 1 of 2
INITIAL EVALUATION AND TREATMENT PLAN

INITIAL FINDINGS:

DESCRIPTION OF PROPOSED TREATMENT PLAN:
1. Inpatient admission.
2. Diagnostic evaluation.
3. Therapeutic programming, including individual and group therapy, recreational therapy and art therapy.
4. Medications as appropriate.
5. Physical evaluation and intervention as necessary.
6. Family and/or significant other assessment.

DESCRIPTION OF PROPOSED RESTRICTIONS AND RESTRAINTS:
1. Locked inpatient unit.
2. Possible use of IM medication and/or seclusion/restraints for controlling aggressive behavior.
3. Removal of unsafe or potentially dangerous items from your possession. e.g., matches, glass or sharp objects. These items will be returned upon discharge if approved by physician.
4. Room search may be done when a patient or others safety is at risk.

__________________________________________  __________________________________________
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.