

INFORMED CONSENT FOR NECESSARY OR EMERGENCY HEALTH CARE

Section I: TO BE COMPLETED BY DCF DESIGNEE AND FORWARDED TO LICENSED MEDICAL PROVIDER

Name of Child:	DOB:	Medical Insurance Info:	Legal Status:
Placement Contact Name and Address:			
Area Office Social Worker:	Phone/Fax:	Supervisor Name:	Phone/Fax:
Qualified Health Care Professional:	Address:		Telephone/Beeper/Fax:

Section II: PROCEDURE OR TREATMENT REQUEST (TO BE COMPLETED BY QUALIFIED HEALTH CARE PROVIDER)

Description of diagnosis including severity:	
Name of procedure or treatment:	
Description of procedure or treatment:	
Other alternatives:	
Type of anesthesia to be used:	
Pre/post-operative care needs:	
Qualified Health Care Provider Signature	Date:

THE UNDERSIGNED, HAVING THE AUTHORITY TO CONSENT ON BEHALF OF THE MINOR NAMED ABOVE, AND HAVING REVIEWED THE EXPLANATION GIVEN BY THE QUALIFIED HEALTH CARE PROVIDER, HEREBY CONSENTS TO SUCH PROCEDURE OR TREATMENT.

Parent's Name and Signature (if child is under an OTC):	Date:
DCF Designee Name/Title:	
Signature:	Date:
DCF Area Office/Careline/DCF Physician on Call:	