Connecticut Department of Children and Families

PERMISSION FOR SPECIALTY CONSULTATION AND EVALUATION

DCF-460B

6/19 (Rev.)

SECTION I: TO BE COMPLETED BY THE DCF SOCIAL WORKER

Child's LAST Name:	Child's FIRST Name:	Child's DOB:	LINK #:	Child's Gender: Select One or enter your own
Name of Medical Insurance Provider:	Group #:	Policy #:	Child's Legal Status: Please Select One	
Placement Contact LAST Name:	Placement Contact FIRST Name:	Placement Contact E-mail:	Placement Contact Phone #:	
Placement Address (No. and Street):		City:	State:	Zip:
SW LAST Name:	SW FIRST Name:	SW E-mail:	SW Phone #:	
SWS LAST Name:	SWS FIRST Name:	SWS E-mail:	SWS Phone #:	
RRG LAST Name:	RRG FIRST Name:	RRG E-mail:	RRG Phone #:	
Date of RRG Review:	RRG Nurse Initials:	DCF Office of SW: Select DCF Office		

SECTION II: ***TO BE COMPLETED IN CONSULTATION WITH PROVIDER***

Speciality Clinic / Provider Name:	Speciality Clinic / Provider E-mail:	Provider Phone #:	
Speciality Clinic / Provider Address (No. and Street):	City:	State:	Zip:
Diagnosis/Rationale Treatment:			
Type (i.e., Radiology, Lab work, etc.):			

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 CONSENT TO SUCH PROCEDURE(S) OR TREATMENT(S).

Parent's Name (if child /youth under an OTC):	Parent's Signature:	Date:
DCF Program Supervisor (or above) name:	DCF Program Supervisor (or above) Title:	
DCF Program Supervisor (or above) Signature:		Date:

This authorization will expire 365 days following the date approved by the Program Supervisor, unless withdrawn in writing. ***Additional consent is required for genetic testing**