Connecticut Department of Children and Families

INFORMED CONSENT FOR NECESSARY OR EMERGENCY HEALTH CARE

DCF-460

11/19 (Rev.)

SECTION I: TO BE COMPLETED BY SOCIAL WORKER				
Child's LAST Name:	Child's FIRST Name:	Child's DOB:	LINK #:	Child's Gender: Select One
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 Nurse LAST Name:	RRG Nurse FIRST Name:	RRG Nurse E-mail:	RRG Nurse Phone #:	
Date of RRG Review:	RRG Nurse Initials:	DCF Office: Select DCF Office		

SECTION II: SPECIALITY TREATMENT REQUEST (TO BE COMPLETED BY QUALIFIED HEALTH CARE PROVIDER)			
Name of Qualified Health Care Professional / Speciality Clnic / Provider:			Phone #:
Address (No. and Street):	City:	State:	Zip:
Diagnosis / Rationale / Treatment:			
Name of procedure or treatment:	Type of anesthesia to be used (if applicable):		
Description of procedure or treatment including risks/benefits:			
Description of any alternatives to proposed procedure or treatment (if applicable):			
Pre-operative care needs (if applicable):	Date of pre-op physical completed:		
Post-operative care needs (if applicable):	Date of follow-up appointment:		
Comments:			
Name of Health Care Provider:	Provider Signature:	Date:	

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

INFORMED CONSENT EXPIRES 30-DAYS AFTER SIGNATURE OR DATE OF PRE-OP PHYSICAL, WHICHEVER COMES FIRST.