Arapahoe/Douglas Mental Health Network
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COMBINED STATEMENT OF MEDICAL DECISION-MAKING AUTHORITY AND CONSENT FOR TREATMENT FOR A MINOR CHILD OR ADULT WARD

_____ ____/____/____ _____

Minor child's or adult ward's name | Date of birth | Client I.D #

I _____ **state and attest** that I may legally consent to medical, mental health and/or substance use treatment for the above listed minor child/adult ward if deemed necessary, advisable and appropriate by ADMHN and its employees, therapists, contractors, etc. I consent under the following authority:

___ **Legal Guardian/Parent**

_____has sole Medical Decision Making Authority.

Medical Decision Making Authority is shared between

_____ _____

Name 1 | Name 2

___ **Department of Human Services Representative** - Department has custody of minor and authority to consent to the treatment of same.

___ **Self –** Minor who is at least 15 years old and wishes to consent to services.

___ **Other** - Please provide explanation: _____

I am aware that on (date) _____, an appointment for the minor child/adult ward listed above is scheduled for the purpose of a **mental health and/or substance use assessment** by ADMHN. I am also aware that following this assessment, it may be necessary, advisable and appropriate that the minor child/adult ward receives treatment from ADMHN. Without the generality of what "treatment" may involve, I understand it may involve individual or family therapy, group therapy, psycho-education, skills building, emergency services, counseling, care coordination, medication or a combination of one or more of these things.

I also authorize (print name) _____to sign any and all papers necessary for the treatment of the minor child/adult ward listed above.

PARENT OR LEGAL GUARDIAN WITH DECISION-MAKING AUTHORITY SIGN THE FOLLOWING:

_____ ____/____/____

Signature Parent or Legal Guardian | Date

_____ ____/____/____

Signature Parent or Legal Guardian | Date

_____ ____/____/____

Signature of Witness | Date

VERIFICATION

I, _____, am the DHS Case Worker for the minor child listed above. After reviewing the Court's order of (date) _____ directing this child be placed in the care of_____, I have found nothing inconsistent with the Court's Order and I am in agreement with any and all assessments/treatments by Arapahoe/Douglas Mental Health Network.

_____ ____/____/____

Signature of DHS Caseworker | Date

_____ ____/____/____

Signature of Witness | Date