DCF-460
08/2011 (Rev.)

STATE OF CONNECTICUT
Department of Children and Families

INFORMED CONSENT FOR NECESSARY OR EMERGENCY HEALTH CARE or REFERRAL

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 or RRG NURSE)

Diagnosis or reason for referral:	
Name of procedure or treatment	
Description of procedure or treatment including risks/benefits:	
Description of any alternatives to proposed procedure or treatment:	
Type of anesthesia to be used:	
Pre/post-operative care needs:	
Comments:	
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/youth under an OTC)	Date:
DCF Designee Name/Title:	RRG Nurse initial (if needed)
Signature:	Date:
DCF Area Office/Hotline/DCF Physician on Call:	