Community Care Resources, Inc.

Partnership In Planning

TREATMENT/MEDICATIONS INFORMED CONSENT

_____ _____
Patient Name Birth Date

_____ _____
C.C.R. Clinician Foster Home

1. Treatment/Medication & Dosage Range:

2. Reason for Treatment/Medication i.e., Medical Condition and/or Behavior:

3. Benefits Expected:

4. Potential Side Effects/Risks or Discomforts (General & Specific):

_____ _____
Physician's Signature Date

The need for and continued use of this treatment/medication will be reviewed at least every 90 days by the physician. Questions about the treatment/medication can be asked by contacting the physician or the staff designee/contact person who will make any necessary arrangements. Consent can be withdrawn at any time with written notification.

By my signature below, I give consent for the above described treatment/medication to be administered, as stated above. My signature also indicates that I understand the reasons for the treatment/medication, its potential risks and its benefits.

Signatures	*Date Signed*
Patient –If not found competent by court to consent	
Staff—I believe the above named patient is able to make an informed decision.	
Parent/Legal Guardian	

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www.CommunityCareResources.com