



**INFORMED CONSENT**  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 STATE HOSPITAL  
 SFN 62154 (10-2023)

When care, treatment, and services require informed consent, all aspects will be discussed with you and/or your legal representative to establish a mutual understanding between you and the hospital. This allows those involved to fully participate in decisions about your care, treatment, or services recommended.

**By signing, you agree that the following was discussed:**

- Nature of the proposed care
- Likelihood of achieving treatment goals
- Risks/Benefits/Side Effects, including potential problems to recovery
- Alternatives considered and risks/benefits of them
- Limitations on confidentiality of Protected Health Information (PHI), if indicated

Name	Date of Birth	Client ID Number
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**LIST EACH PROCEDURE OR MEDICATION REQUIRING CONSENT**

Name of Procedure or Medication	Individual or Legal Representative <input type="checkbox"/> Accepts <input type="checkbox"/> Refuses, explain* <input type="checkbox"/> Emergency, explain*	
*If Refused or an Emergency, Explain Why		
Reviewed		
Individual/Representative Signature	Date	Time <input type="checkbox"/> am <input type="checkbox"/> pm
Staff Signature	Date	Time <input type="checkbox"/> am <input type="checkbox"/> pm

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