

REGIONAL SUPPORT ASSOCIATES

INFORMED CONSENT TO REFERRAL AND PRELIMINARY ASSESSMENT

I, _____,
Name
of _____
Address *City* *Postal Code*

hereby authorize: _____ to make a referral to:
Name of Person or Agency

REGIONAL SUPPORT ASSOCIATES for:

MYSELF or _____ DOB: _____
Client's Name *Date of Birth*

For the following Assessment and/or Treatment:

Describe Services Requested

Signature of Person Referred

Date

*Signature of Legal Guardian or
Substitute Decision Maker*

Relationship to Person Referred

Signature of Witness

Date

Please Note: Where the Person is not of the legal age or lacks legal capacity to give consent, this Consent is to be signed by a Substitute Decision Maker and/or Legal Guardian *prior* to referral to treatment. When consent is signed by the Substitute Decision Maker and/or Legal Guardian, the relationship to the Person referred must be stated. Furthermore, when the Consent is given by the Substitute Decision Maker and/or Legal Guardian, it is most desirable to obtain the Consent and signature of the Person referred as well, provided *he or she has been fully informed* as much as possible.

The Person referred by the Substitute Decision Maker has the right to refuse treatment and/or withdraw Consent even after this Consent is signed. This Consent is good only for the provision of the above-described referral.