Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:

(Name, DOC#, DOB)

CONSENT FOR EVALUATION AND INITIATION OF MENTAL HEALTH TREATMENT

I. The Department of Corrections (DOC) offers mental health evaluations or treatment to patients needing services (see Policy Directive DOC 630.500, Mental Health Services).

II. You have the following rights whether or not you consent to evaluation or treatment:

- ❖ You generally have a right to refuse evaluation and treatment (including medications) at any time. However, if health care staff determine that you are an immediate risk to harm yourself or others or if you meet other requirements (see Policy Directive 630.540, Involuntary Antipsychotic Administration and Policy Directive DOC 610.010, Consent for Health Care), you may be given an evaluation and/or treatment (including medications) against your will.
- ❖ If you elect to refuse recommended mental health evaluation or treatment, you will be informed of possible risks of refusing services (DOC form 13-048).
- ❖ You have a right to review, ask questions about, and offer suggestions related to your mental health treatment. Your suggestions may or may not be followed.
- ❖ You have a right to make a complaint about your mental health evaluation or treatment either to the local Correctional Mental Health Program Manager (CMHPM) or other staff member in charge of mental health if you are not able to resolve the issue with your provider or through a grievance process. NOTE: *You must try to resolve the issue with your provider or his/her supervisor before going to the local mental health staff member who is in charge*.
- ❖ You have a right to review your mental health records, unless there is a clinical reason to prohibit this review. This request must be in writing.
- ❖ You have a right to inquire as to the qualifications of your provider to render a specific treatment.

III. You should be informed about the following before starting a mental health evaluation or treatment (see Policy Directive DOC 610.010, Consent for Health Care):

- ❖ The nature of and reason for the proposed evaluation or treatment.
- ❖ What options you may have other than the recommended treatment.
- ❖ The possible risks and benefits of the recommended evaluation or treatment and of other options you may choose (including no treatment).

NOTE: ***Informed consent does not mean that you are consenting to release information.***
It is important to know that there are times when some information about your mental health may be disclosed to others without your consent. This is only done in accordance with state and federal laws and DOC policies and is limited to the amount necessary to meet the legal or policy requirement.

CONSENT

Place an X in the box next to the statement that applies to you:

	Yes	No	
1.	☐	☐	I have been informed about my rights to consent or not to consent to evaluation or treatment.
2.	☐	☐*	I agree to receive and participate in a mental health *evaluation* at this time.
3.	☐	☐*	I agree to receive and participate in mental health *treatment* at this time.

Specify treatment: _____

My signature below means that I have read or had explained to me the information on this form. I have asked questions about anything that was not clear to me. I understand the information and the checked boxes are correct.

SIGNATURE OF PATIENT/Surrogate decision maker	DATE	SIGNATURE/STAMP OF MENTAL HEALTH PROVIDER	DATE

☐ *The patient refused to sign this form. The marked boxes above indicate statements that apply to the patient.*

For Provider Use Only:

*If **No** to 2 or 3: ☐ The provider reviewed or attempted to review the Refusal of Treatment form (DOC 13-048) with the patient

☐ The patient chose not to sign the Refusal of Treatment form (DOC 13-048)

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.