

McLaren Print System Order

Order No: 47120 Reprint Previous Order No: 9490
Order Date: 2019-07-22
User: shirley liddell
Phone: 810-342-5333

Ship Location: McLaren OakBridge Center PHP - Shirley Liddell
4448 Oakbridge
FLINT, MI 48532

Forms

Quantity: 500
Paragon Dept No: 43560
Dept Name: McLaren OakBridge Center PHP
Company Number: 60

Order Total Price: 18.00

Item Number: MHCC-17170A
Item Description: Outpatient Adolescent Psychiatric Program Consents
Revision Date: 2/2015
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: 5 Hole Top
Misc Info:

McLAREN FLINT
PARTIAL HOSPITALIZATION PROGRAM
OUTPATIENT ADOLESCENT PSYCHIATRIC PROGRAM CONSENTS

I, _____ (Parent/Legal Guardian Name), the parent/legal guardian of _____ (Patient Name), consent to the following regarding my adolescent's treatment at McLaren Regional Medical Center (Day Treatment Program):

- _____ For my adolescent and foster caregivers to be physically assessed at the time of admission to the program, and when clinically indicated to determine the possession of any non-allowable items which may jeopardize safety and health.
- _____ For my adolescent to participate in Pet Therapy and hands-on contact with domestic animals.
- _____ For my adolescent to participate in Reproductive Health Education classes.

This form has been fully explained to me and I am satisfied that I understand its content and significance. I understand that if I have any concerns regarding this consent throughout my adolescent's program admission, I will discuss my concern with my adolescent's physician and that I will withdraw my consent, in writing, if I so desire.

(Date) (Parent/Legal Guardian Signature)

(Date) (Witness Signature)

Persons/people designated to pick your adolescent up:

_____ (Name)	_____ (Relationship)	_____ (Phone)
_____ (Name)	_____ (Relationship)	_____ (Phone)
_____ (Name)	_____ (Relationship)	_____ (Phone)

OUTPATIENT ADOLESCENT
PSYCHIATRIC PROGRAM
CONSENTS
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