St. Clair County Community Mental Health

Telephone Authorization
Guardian Consent

☐ **Psychotropic Medications** (nurse or physician only)	☐ **Other**

Name: _____

Case #: _____

Guardian Name: _____

Phone: _____

Phone Attempts (date/time if applicable):

_____

_____

_____

I verify that _____ (Guardian) was reached by telephone (date) regarding

(attach completed forms or reports of what consent given for, if applicable) _____

_____

_____

☐ Agreement and Consent were given by the guardian on this matter.

☐ Guardian did not give consent.

Guardian Comments:

_____

Registered Nurse Signature/Credentials Date
(required for psychotropic medications)

_____

Case Holder/Clinician Signature/Credentials Date

_____

Phone Witness Signature/Credentials Date
(must speak with the guardian)

INSTRUCTIONS: To be used when guardian consent is necessary for new/changed intervention, and the guardian was not at the clinical meeting. Guardian consent should be obtained prior to implementation of the new/changed intervention, if feasible. All phone attempts should be documented. This form does not replace written approval. A phone witness is required. The RN must obtain consent for psychotropic medications, any other staff person may be the witness.

Clinical Form: #03-0018
Reviewed Date: 09/01/2024
Policy Ref: #03-002-0025, #04-001-0050
EHR: Legal/Consents, Consents for Treatment Note: Telephone Authorization Guardian Consent
EHR: Health Services, Medication Consents (Scanned), Telephone for Psychotropic Meds Note: Telephone Authorization Guardian Consent