

St. Clair County Community Mental Health Authority

Telephone Authorization

Guardian Consent

<input type="checkbox"/> Psychotropic Medications (nurse or physician only)	<input type="checkbox"/> Other
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Name: _____

Phone Attempts (date/time if applicable): _____

Case #: _____

Guardian Name: _____

Phone: _____

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.