Print Form

Ohio Department of Mental Health
Admitting Treatment Permit

Hospital Name: _____

I _____ , authorize the staff of the above named hospital to use any procedures and treatments that are customarily used in a psychiatric hospital, such as counseling, psychotherapy, evaluation, discharge planning and minor medical and minor dental treatment, including medical examination, blood draws, sutures for lacerations, reporting of potentially infections diseases and other notifiable conditions, in the provision of my care and treatment.

I will be asked for consent using a separate form, if either psychiatric medication or specialilzed medical procedures are needed in the course of my treatment here(as defined by ORC 5122.271).

Signature of Patient	Date
Witness Signature	Date

Legal Guardian Consent, if necessary:

Patient has Legal Guardian? ☐ Yes ☐ No	If yes, ☐ Verbal consent obtained ☐ Written consent obtained
Signature of Legal Guardian or Person Authorized to Consent	Date
Witness Signature	Date

☐ Patient refuses to sign ☐ Patient unable to sign Please explain:	
Witness Signature	Date

Nearest relative contact information:

Nearest relative name	Relationship
Street Address	
City, State, Zip	
Telephone Number:	In Whose Name Listed

Plate or Type In	Print Name of RPH Staff who obtains consent
Name: Hospital No.: Sex: Date of Birth:	Signature / Date/Time