

## Informed Consent

The information in the Rights Restriction Review Referral package was completed and/or reviewed with me by:

\_\_\_\_\_

(Name(s) of Person(s) who helped prepare / explain this information)



YES



NO

- Yes**, I was involved in the completion / review of this referral and informed about the Rights Restriction Review process
- No**, I have not been involved or informed regarding the Rights Restriction Review process

I understand that this information will be reviewed by members of the Rights Restriction Review Committee (RRRC).

I understand that the members of the review committee will keep any information shared with them private.

I understand that I can decide if my name and identifying information is shared with the review committee or not.



YES



NO

- Yes**, I'm OK if my name and identifying information is shared with the committee
- No**, I don't want my information shared (consent will be sealed and referral information de-identified before it is provided to the committee)

I understand that I can choose to participate in the review panel meeting in-person (or virtually using Zoom) by myself, or with someone I choose, or not at all.



YES



NO

I have decided that:

**Yes**, I would like to attend the meeting (in person / virtually) - on my own.

**Yes**, I would like to attend the meeting (in person / virtually) - accompanied by the following person:

Name: \_\_\_\_\_

Role/Relationship: \_\_\_\_\_

Contact Information: \_\_\_\_\_

**Yes**, I would like the following person to attend the meeting (in person / virtually) on my behalf (but I don't want to attend):

Name: \_\_\_\_\_

Role/Relationship: \_\_\_\_\_

Contact Information: \_\_\_\_\_

**No**, I don't want to attend the meeting and I don't want anyone to attend on my behalf

I understand that the agency providing my services will receive a response to this restriction review from the RRRRC, and, that all information regarding this review will be kept in my personal file and I can access this information anytime I choose.



YES



NO



### Informed Consent Signatures

\_\_\_\_\_  
Signature / Mark of Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of SDM (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Referral Package includes (in addition to this Informed Consent form):

- Completed Referral form
- Completed Risk Assessment Form
- Completed Supplemental Referral Information form for Psychotropic medications (if applicable)
- Historical Data to support rationale for restriction

This document is available in alternative formats. For assistance, please contact  
(204) 786-1414