

GEORGIA DEPARTMENT OF CORRECTIONS

Facility: _____

MENTAL HEALTH SERVICES

Name: _____

"CONSENT TO RECEIVE SPECIALIZED MENTAL

ID#: _____ DOB: _____

HEALTH TREATMENT"

Race: _____ Sex: _____

You are consenting to receive treatment in the Specialized Mental Health Treatment Unit. This means that you are willing to abide by the rules of the Unit and Treatment Team working with the Unit. The Treatment Team consists of the Counselor, Activity Therapist, Multifunctional Correctional Officer, Psychologist, Psychiatrist, and other designated staff. You are also consenting to follow your Specialized Mental Health Treatment Unit treatment goals.

Upon graduating from the Specialized Mental Health Treatment Unit, which means you have satisfied your Specialized Mental Health Treatment Unit treatment goals and the team decided you have accomplished your treatment goals, you will be returned to your previous living unit or, it may be decided that you will go to the unit that best suits your particular situation and/or current mental health status.

If during the course of treatment, you decide you do not wish to participate in the Specialized Mental Health Treatment Unit, put your request in writing. Then, the Specialized Mental Health Treatment Unit Treatment Team will review your request. You should meet with the Specialized Mental Health Treatment Unit to discuss the reason(s) you no longer wish to participate. During that time your Treatment Plan may be revised.

A copy of this form will be given to you after you have signed it.

Offender Signature

Date

Staff Signature

Date