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|  | **MEDICALLY ASSISTED THERAPY**  **CLIENT CONSENT FORM** | **FORM**  **1A** |

**CLIENT DETAILS**

**Client Name:……………… Nick Name ……………………**

**Sex:………………………………Unique Identifier Code :……………………**

**CSO/Implementing Partners Name ………………….**

**Service Provider’s Name:….……………………………….**

I ………………………………. of telephone number …………………………. and ID number ………………….. (**where the client is under the age of 18 years, state the age of the patient)** ……….. and accompanied by …………………. (if accompanied by a guardian, also indicate the name and details of the guardian). Guardian Name…………………………. Guardian ID……………..

I do hereby willingly consent to the following:

1. That I have been given information at the CSO about the MAT program
2. I have been taken through the rules and regulations of in the MAT program
3. I understand that participation in the program is voluntary
4. I have been informed of the risks and benefits of being in the MAT program
5. Although I understand that the treatment is beneficial to me, I have the right to withdraw from treatment

I have been given an opportunity to ask any questions that will help me make an informed decision

**I FREELY and VOLUNTARILTY agree to undergo MAT at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or any other MAT outlet:**

Client/Guardian Signature/Thumb print: \_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_