



Children and Family Services

MARLENE HAGEN, Director
Human Services

TO: HON.
Judge Commissioner Referee

By
Office
Phone

Department: JUV -
Date
Master J No.

Petitioner

For Court Use Only

SUPERIOR COURT OF CALIFORNIA
COUNTY OF SAN BERNARDINO
JUVENILE DIVISION

In the Matter of
DOB
a minor

J No:
DECLARATION OF
AND REQUEST FOR ORDER FOR SPECIFIC NON
ROUTINE MEDICAL/DENTAL SURGICAL
TREATMENT

I (physician/dentist)
hereby declare:

- 1. That the following treatment is medically/dentally required:

based on (diagnosis)
for (patient's name)

(SW completes #2 through #6, as applicable)

- 2. The child currently resides with:

(name/relationship)
(address)
(phone)

3. Child currently hospitalized at (name) _____
 at (address) _____
4. Parent(s) name(s) _____
 Address of Mother _____
 Phone _____
 Address of Father _____
 Phone _____
5. Efforts to contact parents: _____

6. If parents refusing treatment, why? _____

7. Description of Procedure: _____

8. Consequences of not providing treatment: _____

9. Description of risk involved in this procedure: _____

10. Description of risks associated with anesthesia: Check those that apply: Shock Anaphylaxis
 Respiratory Depression Respiratory Failure Cardiac Failure Death Other Explanation: _____

11. Requesting Physician/Dentist consulted with child's primary physician/dentist regarding the use of sedation/general anesthesia for procedure.
- Date _____ Primary Physician/Dentist Name _____
 Primary Physician/Dentist Initials _____

I declare, under penalty of perjury, that the information in the foregoing is true and correct to the best of my knowledge.
 Executed at _____ California.

 Requesting Physician/Dentist Signature

 Date

Mailing address: _____

Telephone: _____ FAX _____

A report of ___ pages, written by _____ M.D., DD, dated _____ is attached hereto and is made a part of this report hereby.

It is recommended that Court make the orders described below:

 Social Worker Signature

 Date

 Supervisor Signature

 Date

Social Worker Name _____

Supervisor Name _____

Phone No. _____

Phone No. _____

Minor's Att. _____ Notice Date: _____ Time: _____ <input type="checkbox"/> Email: _____ <input type="checkbox"/> Phone: _____ <input type="checkbox"/> Agreed <input type="checkbox"/> Message Left <input type="checkbox"/> Object _____ <hr/> <input type="checkbox"/> Set for Hearing <input type="checkbox"/> See Attached	FA's Att. _____ Notice Date: _____ Time: _____ <input type="checkbox"/> Email: _____ <input type="checkbox"/> Phone: _____ <input type="checkbox"/> Agreed <input type="checkbox"/> Message Left <input type="checkbox"/> Object _____ <hr/> <input type="checkbox"/> Set for Hearing <input type="checkbox"/> See Attached		
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 5px;"> Mo's Att. _____ Notice Date: _____ Time: _____ <input type="checkbox"/> Email: _____ <input type="checkbox"/> Phone: _____ <input type="checkbox"/> Agreed <input type="checkbox"/> Message Left <input type="checkbox"/> Object _____ <hr/> <input type="checkbox"/> Set for Hearing <input type="checkbox"/> See Attached </td> <td style="width: 50%; padding: 5px;"> Att. for _____ Notice Date: _____ Time: _____ <input type="checkbox"/> Email: _____ <input type="checkbox"/> Phone: _____ <input type="checkbox"/> Agreed <input type="checkbox"/> Message Left <input type="checkbox"/> Object _____ <hr/> <input type="checkbox"/> Set for Hearing <input type="checkbox"/> See Attached </td> </tr> </table> <p style="margin-top: 10px;"> Distributed to attorneys <input type="checkbox"/> _____ by (CFS Clerk's initials) Judge/Commissioner will make appropriate orders 5 court days after date of distribution unless Matter set for Hearing. </p>		Mo's Att. _____ Notice Date: _____ Time: _____ <input type="checkbox"/> Email: _____ <input type="checkbox"/> Phone: _____ <input type="checkbox"/> Agreed <input type="checkbox"/> Message Left <input type="checkbox"/> Object _____ <hr/> <input type="checkbox"/> Set for Hearing <input type="checkbox"/> See Attached	Att. for _____ Notice Date: _____ Time: _____ <input type="checkbox"/> Email: _____ <input type="checkbox"/> Phone: _____ <input type="checkbox"/> Agreed <input type="checkbox"/> Message Left <input type="checkbox"/> Object _____ <hr/> <input type="checkbox"/> Set for Hearing <input type="checkbox"/> See Attached
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ORDERS:

Upon reading the sworn declaration and good cause appearing, **It is hereby Ordered that:**

1. The above described medical/dental procedure and related necessary treatment may be administered to the above mentioned minor under the conditions noted above. All other orders remain in full force and effect.

2. Other:

Date: _____ Signed: _____

County Clerk _____