Health and Therapy for Women

INFORMED CONSENT FOR PSYCHIATRIC MEDICATION

Purpose of this form: This form documents that you as the client and your provider have discussed your medication to your satisfaction. Your provider has prescribed the following medication(s). Your provider has either told you about the medication, given you written information about the medication, or both.

You are entitled to know the following information before deciding to take the recommended medication(s):

1. Your condition and/or diagnosis.
2. Symptoms the medication will reduce and how likely the medication will work.
3. Probability of getting better without the medication.
4. Other reasonable treatments that are available.
5. Name, dosage, frequency, route of administration, maximum daily dose and duration of medication(s).
6. Special instructions associated with the medication, if any.
7. Probable side effects of the medication(s) known to commonly occur, and any particular side effects that are likely to occur in your particular case.
8. Ability to drive, operate machinery, or other skilled tasks may be impaired by the medications. Alcohol or illicit drugs may worsen this effect
9. If you are pregnant, plan to become pregnant, or breastfeeding, your provider should be notified. Medications may pose known or unknown risks to the fetus or infant.
10. Any special instructions about taking the medication(s).

By signing this form, you indicate that the medication(s) prescribed has been explained to you to your satisfaction. Even after signing, you can still refuse any dose or withdraw your agreement at any time.You can request a copy of this consent form.

My signature below acknowledges that I have read and understood the above information and agree to the terms stated. I indicate that the medication(s) prescribed have been fully explained to my satisfaction. I have had the opportunity to receive information about the recommended medication(s) and I consent to this treatment. Even after signing, I can still refuse any dose or withdraw treatment at any time. If I have questions pertaining to the medication(s) prescribed, I will make further inquiries prior to signing this consent. I am entitled to a copy of this agreement.

Print name_____

Relationship (if minor) _____

Signature _____

Date _____

Provider Signature_____Date_____