# Family Touch Consent for Use of Behavior- Modifying Medications

| MEMBER NAME (LAST, FIRST, M.I.) | | DATE: |
|---|---|---|
| **MEDICATION PRESCRIBED** | **POSSIBLE SIDE EFFECTS** | IF PROVIDED, MAX DOSAGE RECOMMENDED BY PHYSICIAN |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

By prescribing the medications listed above the physician has determined that the expected benefits outweigh the potential risks. The responsible person or any Team Member is invited and encouraged to attend any psychotropic medication reviews.

The consent remains in effect until such time as the medication is discontinued, dosage exceeds maximum dosage, or the consent is withdrawn through written communication.

**INFORMED CONSENT**

I, the undersigned, have received and understand the information concerning the expected results and side effects.

I hereby give my consent to the use of this medication:

| MEMBER/RESPONSIBLE PERSON'S SIGNATURE | DATE: |
|---|---|
| | |