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ALLERGY ASTHMA SLEEP MEDICINE

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BEHAVIORAL MEDICINE
Child • Adolescent • Adult Psychiatry

PATIENT CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION

Your attending physician has recommended that you be treated with psychotropic medication. You may be treated with psychotropic medications only after you have been informed of your right to accept or refuse such medications. In order to allow you to make an informed decision, you must be provided with sufficient information regarding such medications, which shall include the following:

1. The nature of your mental condition.
2. The reason for you taking such medication, including the likelihood of your improving of not improving without such medications, and that your consent, once given, may be withdrawn at any time by your stating such intention to any member of the treating staff.
3. The reasonable alternative treatments available, if any.
4. The type, range of frequency, and amount (including use of PRN orders), methods of administration, and duration of taking the medications.
5. The probable side effects of these drugs know commonly to occur, and any particular side effects likely to occur in your particular care.
6 There are possible additional side effects which may occur if you take some medications beyond three months. You should have been advised that such side effects may include persistent involuntary movement of the face or mouth or might at times include similar movements of the hands or feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued (your doctor will tell you if this side effect may apply to the medication recommended for you).

- ☐ Anxiety agents, specifically _____
- ☐ Antidepressant, specifically _____
- ☐ Antipsychotics, specifically _____
- ☐ Stabilizers, specifically _____
- ☐ Psychostimulants, specifically _____
- ☐ Sedative/hypnotics, specifically _____

☐ Other_____

☐ Your signature below constitutes: (1) that you understand the foregoing; (2) that you have received all the information you desire; and (3) that you consent of authorize to the administration of such medications.

☐ You verbally agree to take the medication but refuse to sign the consent form. You acknowledge; (1) that you understand the foregoing; (2) that you have received all the information you desire; and (3) that you consent or authorize to the administration of such medications.

☐ You ask that your physician not explain all of the above because you feel it will cause you distress, and you consent to receive these medications as your physician prescribes them.

Patient/Conservator signature	Date	Time
Witness signature	Date	Time
Physician signature/ Block Print	Date	Time