AJ PSYCHIATRY

Medication Consent Form

I have discussed the following information in a simple, non-technical language with my Physician/Nurse Practitioner:

1. The diagnosis and target symptoms for the medication recommended;
2. The possible benefits/intended outcome of treatment with the medication;
3. The possible consequences of not taking the recommended medication;
4. The possible alternatives and why the Physician/Nurse Practitioner reject the alternative treatment;
5. The fact that side effects of varying degrees of severity are a risk of all medication;
6. The relevant side effects of the medication, including:
    A. any side effects which are known to frequently occur in most individuals;
    B. any side effects to which the individual may be predisposed; and
    C. the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia;
7. The need to advise staff immediately if any of these side effects occur;
8. My right to actively participate in my treatment by discussing medication concerns or questions with my Physician/Nurse Practitioner; and
9. My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment is required in a Court Order or in a Special Treatment Plan).

I understand the medication information that has been provided to me. By signing below, I agree to the use of each medication.

_____

(*Signature of patient or legal guardian*)

_____

(*Printed name*)

Date: _____