"CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328"

PSYCHIATRIC MEDICATION CONSENT

DOB: _____

Client Name_____MRN Number _____

I acknowledge that I have discussed with my (or my child's) prescriber my (or his/her) prescription of psychiatric medication(s) specified in this consent form, the reason(s) for taking such medication(s), and reasonable alternative treatment(s) available.

The REASON(S) diagnosis(es), symptoms and/or behaviors for taking the following psychiatric medication(s) are:

_____

_____

_____

***All side effects indicated below could happen after either short term or long term (> 3 months) of medication treatment. Best effort is made here to address notable or likely side effects, but not all possible side effects could be listed or even predicted. It is important to always inform your prescriber as soon as possible any side effects that occur.**

☐ **Potential side effects that are of common concerns to all drugs**: allergic reactions, nausea, vomiting, headache, dizziness, fatigue, dry mouth, constipation, diarrhea, weight change, change in sleep and alertness, movement disorder, sexual dysfunction, birth defect, **and when the medication use is >3months:** osteoporosis, tardive dyskinesia, liver/kidney dysfunction, blood disorders; and ones below that are associated with a particular category of medication:

☐ **Antipsychotic (name, daily min/max dose, frequency range, route, duration)** _____

_____

_____

Additional possible side effects: increased blood sugar/lipids, blurred vision, restlessness, tremor, stiff muscles, neuroleptic malignant syndrome (high fever, rigidity, delirium, circulatory and respiratory collapse), seizures, irregular heart rhythm, increased risk of stroke and death in the elderly with dementia; **treatment >3months:** diabetes, metabolic syndrome, decreased blood cells, **tardive dyskinesia (involuntary movements of the head, neck, limbs which may be irreversible and may appear after medications have been discontinued)**. Other side effects (specify if after >3 months treatment): _____

☐ **Antidepressant (name, daily min/max dose, frequency range, route, duration)** _____

_____

_____

Additional possible side effects: blurred vision, urinary retention, seizures, blood pressure dysregulation, irregular heart rhythm, **mood changes, irritability, violence, suicidal thoughts and behavior (especially in youth); treatment >3months:** sexual dysfunction, metabolic syndrome, tardive dyskinesia. Other side effects (specify if after >3 months treatment): _____

_____

☐ **Antianxiety/Hypnotic (name, daily min/max dose, frequency range, route, duration)** _____

_____

_____

Additional possible side effects: trouble concentrating, confusion, clumsiness, loss of inhibition, adverse synergistic effect with alcohol and other drugs, including opioid analgesics; **treatment >3months:** tolerance/dependency, addiction. Other side effects (specify if after>3 months treatment): _____

_____

_____

_____ (client/legal guardian's initials)

☐ **Mood Stabilizer (name, daily min/max dose, frequency range, route, duration)** _____
_____
_____
Additional possible side effects: serious rash/mucosal blister, potentially life-threatening, confusion, liver/pancreas dysfunction, decreased blood cell, birth defects; **treatment >3months:** hyponatremia, ovarian problems (valproic acid). Other side effects (specify if after >3 months treatment): _____

☐ **Lithium (daily min/max dose, frequency range, route, duration)** _____
Additional possible side effects: thirst, increased urination, tremors, birth defects; **treatment >3months:** acne, thyroid disorder, kidney failure. Other side effects (specify if after >3 months treatment): _____

☐ **Attention Deficit Hyperactivity Disorder Medication (name, daily min/max dose, frequency range, route, duration)** _____
_____
Additional possible side effects: decreased appetite/growth, restlessness, blood pressure/heart rhythm dysregulation. **Atomoxetine:** rare liver injury with possible jaundice, abdominal pain, dark urine, flu-like symptoms. **Stimulants:** psychosis, suicidal ideation, aggression, sudden unexplained death, primarily with (undetected) underlying cardiac structural abnormalities; **treatment >3months:** tolerance/dependency, addiction. Other side effects (specify if after >3 months treatment):_____
_____

☐ **Anti-Parkinson Medication** (name, daily min/max dose, frequency range, route, duration) _____
_____
Additional possible side effects: blurred vision, mental dulling, and trouble urinating; **treatment >3months:** sexual dysfunction, glaucoma, bowel dilation. Other side effects (specify if after >3 months treatment):
_____

☐ **Other Psychiatric Medication (name, daily min/max dose, frequency range, route, duration)**
_____
_____
Possible side effects (specify if after >3 months treatment): _____
_____

I have been informed of reasonable ALTERNATIVE TREATMENT(S) listed below and the likelihood of improving or not improving without the above medication(s) (this must be completed): _____
_____

Other topics we discussed:

1. Possible drug interactions that may occur with other medications and drugs. I agree to notify my/my child's prescriber regarding any medication(s), or changes in medication(s), prescribed by other prescriber(s), and regarding use, or changes in use, of over-the-counter drugs or natural/herbal supplements.

2. Potential medication risk to an unborn baby or a new born being breast fed, and I have told my/my child's prescriber whether I am/my child is currently pregnant or breast feeding. I agree to inform my prescriber if there is any possibility or intention of my/my child's becoming pregnant or doing breast feeding.

_____ (client/legal guardian's initials)

3. Because they alter the mind, **alcohol and/or recreational/street/illicit drugs should be avoided**. They can also cause dangerous interactions and can adversely affect the intended actions of prescribed medications.

4. I am/my child is aware that medications can impair the ability to drive or operate equipment. I/my child should avoid driving or using heavy machinery until I know/my child knows how the medication(s) prescribed could affect me/my child. I take responsibility for maintaining the safety of myself/my child, and the safety of others.

5. I agree/my child agrees to take/administer the medication(s) as prescribed and, especially when starting meds or during changing doses, to watch for and contact my/my child's prescriber about any unusual or adverse effects. Emergency/911 will be contacted if adverse effects are serious.

6. Discontinuing medications, especially abruptly, can cause serious adverse effects. I agree to discuss stopping medications with my/my child's prescriber before doing so, and to follow medical advice about safely tapering medications if intending to discontinue medications.

7. The medication(s) is/are selected based on best evidence supported by clinical literatures, guidelines, and expert opinions, even though sometimes a particular medication might not have U. S. Food and Drug Administration approval for the use(s) and dose range discussed.

Acknowledgement and Agreement

I acknowledge that the above topics were covered to my satisfaction, and that I have consented to, and accepted the risks of treatment with the medication(s) indicated in this form. I also understand that I have the **right to refuse** this/these medication(s) and that it/they cannot be administered to me/my child without my consent. I may seek further information at any time that I wish, and I **may withdraw my consent** to treatment with the above medication(s) at **any time** by stating my intention to my/my child's prescriber. I certify with my signature that I have legal authority to sign this consent and that the relationship listed is valid and legal.

_____ _____

Client (or Parent or Legal Guardian/ Conservator) Signature Date

_____

Print Name if not client/ Legal Relationship

_____ _____

Prescriber Signature Date

_____

Prescriber Print Name/Credentials

_____

Name of Clinic

_____

Clinic Address