Medication Consent Form

NAME: _____

DATE OF BIRTH: _____

My physician and I discussed:

1. The nature of my medical condition.
2. The reasons that my physician has for prescribing the medication, including the likelihood of my condition improving or not improving without the medicine.
3. I can refuse to take the medication at any time, but should discuss this with my doctor and treatment team
4. Reasonable alternative treatments available for my condition.
5. The type of medication that I will be receiving, the frequency and range of dosages, and duration of such treatment.
6. The side effects of these drugs known to commonly occur, and any particular side effects likely to occur in my particular case.
7. The possible additional side effects which may occur if I take some medications beyond three months, including tardive dyskinesia which is persistent involuntary movements of the face, mouth, hands or feet. Certain antipsychotic medications can cause these symptoms which are potentially irreversible, and may appear after the medications have been discontinued.
8. I understand that I should discuss all my medical problems and any medication that I take with my physician(s).
9. I understand that medications prescribed are FDA approved but that their use may not appear as part of their approved labeling.

Date	Medication	Purpose	Pt signature	Guardian Signature