PATIENT/GUARDIAN/PARENT CONSENT TO TREATMENT WITH SPECIFIED MEDICATIONS

PLEASE READ THIS FORM CAREFULLY

Dr. _____ has met with me and we discussed ☐ ***my*** ☐ ***the conservatee's*** illness or ☐ ***my child's***
(Print First and Last Name)

condition which requires treatment. The doctor has recommended treatment of this illness or condition with psychotropic medications. I have been provided with the following information by the doctor prescribing such medications:

1. The nature of the mental illness/condition
2. The reasons for taking such medications, including the likelihood of improving or not improving without such medication, and that my consent, once given, may be withdrawn at any time by my stating such intention to any member of the treating staff.
3. The reasonable alternative treatment available, if any.
4. The type, frequency, amount, method (oral or injection), and duration of medication treatment.
5. The side effects that this/these particular medication(s) may cause, as well as side effects which may occur because of physical or medical condition(s) that I/my conservatee/my child may have or interaction with other medications or foods. If the doctor has prescribed neuroleptics, he or she has discussed with me the possible complication of tardive dyskinesia, its symptoms and implications.
6. The possible consequences of abrupt discontinuation of this medication and ways to avoid these consequences.
7. The possible additional side effects which may occur when taking such medication beyond three months.
8. I have the right to request and be provided whatever additional information I desire.

INSTRUCTIONS:

Physician - Circle medication classification, add name of medication where indicated, and specify dose range per day.
Patient/Guardian - Initial in appropriate space next to classification explained to you.

Medication Classification	Dose Range/Day	Patient/Guardian Initial
Neuroleptics: _____	Up to _____ mg	_____
_____	Up to _____ mg	_____
Lithium Carbonate: _____	Up to _____ mg	_____
Antidepressants:		
Monoamine Oxidase Inhibitors:_____	Up to _____ mg	_____
Other Antidepressants:_____	Up to _____ mg	_____
_____	Up to _____ mg	_____
Stimulants:_____	Up to _____ mg	_____

☐ Patient/Parent/Guardian given supplementary written materials pertaining to the above prescribed medication(s).

My signature below constitutes acknowledgment that: (1) I have read and agree to the foregoing; (2) the medications and treatment set forth above have been adequately explained and/or discussed with me by my doctor, and I have received all of the information I desire concerning such medication and treatment; and (3) I authorize and consent to the administration of such medications and treatment.

Patient's/Guardian's/Parents Name: ***(Print First and Last Name)***	Patient's/Guardian/Parent's Signature:	Date:	Time:
Physician's Name: ***(Print First and Last Name)***	Physician's Signature:	Date:	Time:
*Witness' Name: ***(Print First and Last Name)***	Witness' Signature:	Date:	Time:

*** RN signature required for telephonic consent only.**