Fern River Psychiatry

CONSENT TO PSYCHOTROPIC MEDICATION

I, _____, hereby consent to and authorize the physician responsible for this care to administer the following medication for treatment of my _____.

_____

(medication)

The physician responsible for this care has informed me that the proposed medication may help to improve how I feel and/or function and the length of time that I may expect to take such medication. The physician also has informed me of the available alternatives to such medication and, as appropriate, their usual and most frequent risks and hazards.

The physician responsible for this care also has informed me of the usual and most frequent risks and hazards of the proposed medication, including the following common side effects:

_____

_____

If the medication is a major tranquilizer, I understand that I also may experience tardive dyskinesia (TD) which causes involuntary tic-like movements in the face, tongue, neck, arms and/or legs and which may continue even after the medication is stopped.

I understand that I should immediately contact the physician responsible for this care if I experience any side effects or notice any unexpected change in my condition. Although the physician believes that this medication will help in the treatment of my illness, I further understand that it may not.

I understand that taking the prescribed medication is my choice. I may stop such medication at any time, but should inform my physician if I plan to stop. Some medications should be reduced gradually and not stopped all at once.

It is my further understanding that if I have additional questions regarding the prescribed medication, I may call the prescriber of the medication.

_____ _____

Signature of Patient or Authorized Representative | Date / Time

_____ _____

Printed Name of Patient or Authorized Representative | Relationship of Authorized Representative

_____ _____

Physician Signature | Date / Time

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