Behavioral Health and Education Specialists

Informed Consent for Prescribed Medication

Patient Name: _____ Patient Date of Birth: _____

Psychiatrist Name: _____

Medication	Reason For Medication	Dosage	Times /Freq	Method	Check If Off-Label	Start Date	End Date	Was It Effective?
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No
					❑Off-Label			❑Yes ❑No

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Psychiatrist Name: _____

If you do not understand any of the information below, ask your psychiatrist for an explanation prior to initialing that statement. Your psychiatrist will answer all of your questions to the best of his/her ability. We want to assure you are properly informed about the medications you are being prescribed and have your questions answered.

*****Please Read and Initial The Following Statements Prior to Your Session*****

Your treatment with psychotropic medications will be prescribed to you by your psychiatrist. Your initials below indicate you have read and understand the following statements. You understand you will have the opportunity to discuss any of these statements with your psychiatrist and that your psychiatrist will specifically discuss and make clear each of the statements listed below before you start taking a medication. Also, you understand you will have the opportunity to ask your psychiatrist any questions you may have.

- I understand any medication(s) I am prescribed is/are being prescribed to treat my psychiatric symptom(s) and condition(s). Patient/Patient's Legal Guardian's Initials: _____
- I understand my consent permits the dosage of my medication(s) to be changed within the anticipated range without having to sign a new consent. Patient/Patient's Legal Guardian's Initials: _____
- I understand there is a risk I could develop serious side-effects from the medication(s) I am prescribed and that the possible medication side-effects will be explained to me prior to starting the medication(s). Patient/Patient's Legal Guardian's Initials: _____
- I understand the probable risk(s) of not taking the proposed medication(s) will be reviewed with me and that I will be allowed to ask questions about that information. Patient/Patient's Legal Guardian's Initials: _____
- I understand there are no laboratory tests which will predict if I am at an increased risk for any fatal condition(s) caused by the above-listed medication(s). Patient/Patient's Legal Guardian's Initials: _____
- I understand some medications may require blood work before I start being treated with them and periodically thereafter as clinically indicated. I understand that although this blood work may help detect drug-induced conditions, it may do so only after significant, irreversible and/or potential fatal damage has occurred. Patient/Patient's Legal Guardian's Initials: _____
- I understand I must immediately report any unusual symptoms to my psychiatrist; I will be especially aware of any rashes, easy bruising, bleeding, sore throats, fever and/or dark urine. My psychiatrist can be contacted at 815-609-1544. Patient/Patient's Legal Guardian's Initials: _____
- I understand my prescribed medication(s) may increase the risk of having suicidal thoughts and behaviors and that I must immediately report any unusual changes in my mood, behaviors, symptoms of depression, or thoughts of self-harm/suicide to my psychiatrist. My psychiatrist can be contacted at 815-609-1544. Patient/Patient's Legal Guardian's Initials: _____

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- I understand the medications prescribed to me have been approved by the Federal Drug Administration (FDA). I also understand that if no FDA approved medications are available to treatment my psychiatric condition(s), my psychiatrist may recommend Off-Label use of one or more FDA approved medications. I understand I will be informed of any Off-Label use of the medications prescribed to me and that the possible risks associated with such Off-Label use (a list of which will be provided to me), will be explained to me and that I need to agree to use the identified Off-Label medications as prescribed.
  Patient/Patient's Legal Guardian's Initials: _____
- My psychiatrist will discuss alternative methods of treatment with me. Patient/Guardian Initials: _____
- I agree to read the provided psychiatric medication educational information about my prescribed medication(s). Patient/Patient's Legal Guardian's Initials: _____
- I understand I have the right to withdraw my consent to be treated with psychotropic medications at any time by doing so in writing. Patient/Patient's Legal Guardian's Initials: _____

Do Not Sign Below Until You Are In Your Session With Your Psychiatrist

My signature below indicates I have read the above provided information, understand everything that I read and was presented to me by my psychiatrist, and that my questions were answered to my satisfaction. It also indicates I understand the proposed benefits, risks and side-effects of the proposed medication(s).

Patient/Patient's Legal Guardian's Signature: _____ Date: _____

Psychiatrist Statement:

I, the treating psychiatrist, have fully explained to the patient and/or patient's legal guardian(s) the nature, purpose and potential risks associated with the above-listed medication(s). I have fully explained the reason(s) for prescribing the medication(s), the potential benefits of the medication(s), the potential side-effects associated with the medication(s), the available possible alternative treatment(s) for the diagnosed psychiatric condition(s), and the possible risks to the patient of not taking the proposed medication(s). I have asked the patient and or patient's legal guardian if he/she has any questions regarding the information I have provided and I have answered those questions to the best of my ability.

Psychiatrist Signature: _____ Date: _____