Informed Consent for Psychotropic Medication Treatment

Name of Patient: ________________________________

My practitioner has discussed the following for each medication listed below:

- The diagnosis and target symptoms for the medication(s) recommended (which may or may not be FDA indicated)
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment and possible alternatives. The possible results of not taking the medications.
- The possible risks associated with medication(s), (including any contraindications and increased risks associated with taking medications with pregnancy or as a child/adolescent/young adult).
- Common or significant adverse effects that are associated with meds. Additional info provided (wccmw.com ____ printout____ brochure____ verbal___ other (specify)________________)
- Meds should not be combined with illicit substances, alcohol, OTC meds, or prescribed meds until discussed with the provider.
- The possibility that my medication dose may need to be adjusted over time, with regular visits to my practitioner;
- The possible need for regular laboratory monitoring;
- My right to actively participate in my treatment by discussing medication concerns or questions with my practitioner; and inform the practitioner of any changes in medication regimen with other doctors;
- Further, I understand that there is no guarantee that the agent will be effective with my symptoms. I agree to notify my practitioner with any changes or problems with my medications.
- My right to withdraw voluntary consent for medication at any time
- The following was also discussed during the consent process

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Prescribed Medication(s) for consent on this date:

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Patient/Guardian Signature ______________________________ Date ______________

Practitioner Signature________________________________ Date____________________

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