Noble Health Associates

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

NAME / MRN

Your physician has prescribed the psychotropic medication(s) listed below. In order to make an informed decision, you must be provided with information (verbal and/or written) including the following:

1. The nature of your psychiatric condition (diagnosis).
2. The reasons for taking such medication(s), include the likelihood of improving or not improving without such medication(s).
3. The name, dosage, frequency, route of administration and duration of prescribed medication(s).
4. The possible side effects of the medication(s) known to commonly occur and may possibly cause birth defects.
5. Additional side effects may occur with continued administration of an Antipsychotic medication(s) if taken for *more than three (3) months*. Side effects may include persistent involuntary movements of the face, mouth, limbs, and trunk, called tardive dyskinesia. These symptoms may be irreversible and may continue to appear even after the medication(s) has been discontinued.
6. Duration and continuation of medication(s) will be discussed with you and your treating Psychiatrist/Nurse Practitioner during each visit.

▫ Antidepressants/Name of Medication: _____ Dosage: Frequency up to: mg/day	By Mouth Duration: ☐ 24 mos ☐ 12 mos ☐ Other _____
▫ Antipsychotics/Name of Medication: _____ Dosage: Frequency up to: mg/day	By Mouth Duration: ☐ 24 mos ☐ 12 mos ☐ Other _____
▫ Stimulants/Name of Medication: _____ Dosage: Frequency up to: mg/day	By Mouth Duration: ☐ 24 mos ☐ 12 mos ☐ Other _____
▫ Mood Stabilizers/Name of Medication: _____ Dosage: Frequency up to: mg/day	By Mouth Duration: ☐ 24 mos ☐ 12 mos ☐ Other _____
▫ Anxiolytics/Name of Medication: _____ Dosage: Frequency up to: mg/day	By Mouth Duration: ☐ 24 mos ☐ 12 mos ☐ Other _____
▫ Sedative/Hypnotics /Name of Medication: _____ Dosage: Frequency up to: mg/day	By Mouth Duration: ☐ 24 mos ☐ 12 mos ☐ Other _____
▫ Anticholinergics/Name of Medication: _____ Dosage: Frequency up to: mg/day	By Mouth Duration: ☐ 24 mos ☐ 12 mos ☐ Other _____
▫ Other (Classification/Medication): _____ Dosage: Frequency up to mg/day	By Mouth Duration: ☐ 24 mos ☐ 12 mos ☐ Other _____
▫ Antipsychotic(Injectable)/Medication: _____ Dosage: Frequency up to mg	Route: ☐ IM ☐ SQ Duration: ☐ 24 mos ☐ 12 mos ☐ Other _____

Reasonable Alternative Treatments Available, if any:

☐ Psychotherapy ☐ Family Therapy ☐ Group Therapy ☐ Other Meds _____ ☐ Other: _____

Your signature below acknowledges that:

- The above medication(s) and treatment have been adequately discussed with you and should be taken only as prescribed.
- You have received all of the information you desire concerning such medication(s) and treatment.
- I have received ***Medication Information Sheet(s)*** and have had an opportunity to review with the prescriber the specific benefits and side effects of prescribed medicine(s). **Patient/Guardian initial: _____**

I hereby give my consent to treatment with this medication. I understand that I may seek additional information, and that I may withdraw this consent at any time by stating my intention to any member of the treatment team.

Patient Signature*: _____Date: _____

Guardian / Conservator Signature (If Applicable): _____Date: _____

Physician/NP Signature:_____Date: _____

Witness (if verbal consent):_____Date: _____

**Unable to obtain Patient/Parent/Guardian/Conservator signature – Document Reason:*