

## Consent for Medication

---

I, \_\_\_\_\_ give my consent to take the medications (listed below), which are used to treat mental and emotional disturbances. Their use has been explained to me by my physician, Dr. \_\_\_\_\_, including the following information:

- A. The nature of my emotional condition.
- B. The reasons for taking such medication, including the likelihood of my condition improving or not improving.
- C. Other forms of treatment available to me, if any.
- D. The type, frequency, and amount of each medication, as well as the method (by mouth, injection, etc.), and how long I will need to take them.
- E. The side effects of these medications which commonly occur and ones which may particularly affect me.
- F. The possible side effects of certain medications which may occur if I take them longer than three months, including uncontrollable body movements, also that these symptoms may be irreversible and may appear after the medications have been stopped.
- G. The potential adverse effects on fetal development, if applicable.
- H. It is my responsibility to read insert.

**MEDICATIONS PRESCRIBED:**

**Date Started**

**Patient's Initials**

---

---

---

---

---

---

---

---

I understand that I may withdraw my consent at any time by telling any member of the treating staff.

---

Signature of Physician

Date/Time

---

Signature of Patient/ Legal Guardian

Witness