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