MACOMB COMMUNITY MENTAL HEALTH SERVICES

PSYCHOTROPIC MEDICATION INFORMED CONSENT

ClientName: _____Case # _____Program:_____

Dr. _____ has explained to me that I have a psychiatric illness. To treat my illness, the doctor recommends treatment with:

MEDICATION	INDICATION	DOSAGE RANGE mg/day
A.		
B.		
C.		
D.		
E.		
F.		

I was provided with:[ ] Patient Medication Instruction Sheet and [ ] an Oral Explanation of the medications prescribed. The known side effects were explained to me, and I was given the opportunity to discuss the medication with my doctor including the risk and benefits of medication, alternative treatments and the possibility of side effects not currently reported. While medications of this type have been used successfully in the treatment of others with symptoms similar to mine, I understand that no guarantee can be made that any of these agents will be effective in the treatment of my particular symptoms.

The risk of:

Tardive Dyskinesia	[ ] Applicable	[ ] Not Applicable
Metabolic Syndrome	[ ] Applicable	[ ] Not Applicable

has been explained to me in detail.

Also I will inform my doctor if I am pregnant or plan to become pregnant to discuss medication issues. To my knowledge, [ ] I am not pregnant. [ ] I am pregnant. [ ] Not applicable.

I voluntarily consent to take this medication. I also understand I have the right to withdraw my consent and stop taking the medication at any time.

_____ _____

[ ] Consumer [ ] Guardian [ ] Parent Name Signature Date

_____ _____

Physician Name Physician Signature Date

A new signed consent is required once a year, when a new medication is started and when the dosage exceeds the maximum FDA recommended dose.