INFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

1] NAME OF MEDICATION: ___________________ ADMINISTERED: ☐ by mouth ☐ by injection
This medication is in the class: ☐ Antipsychotic ☐ Antidepressant ☐ Mood Stabilizer
☐ Psycho-stimulant ☐ Anti-Anxiety ☐ OTHER (specify): ______
THIS MEDICATION IS INTENDED TO HELP WITH: ______
INITIAL DOSE: You (your child) will begin taking this medication as follows-dose/frequency: ______
Anticipated maximum daily dose is: ______ mg per day. Anticipated duration for this medication is: ______
ALTERNATIVES: Alternatives to the use of this medication for your (or your child’s) condition include:
☐ Psychotherapy ☐ Other medication ☐ Family Therapy ☐ Group Therapy ☐ Other: ______
WITHOUT such medication, your (child’s) condition:
☐ is unlikely to improve. ☐ may or may not improve. ☐ is likely to improve.

2] NAME OF MEDICATION: ___________________ ADMINISTERED: ☐ by mouth ☐ by injection
This medication is in the class: ☐ Antipsychotic ☐ Antidepressant ☐ Mood Stabilizer
☐ Psycho-stimulant ☐ Anti-Anxiety ☐ OTHER (specify): ______
THIS MEDICATION IS INTENDED TO HELP WITH: ______
INITIAL DOSE: You (your child) will begin taking this medication as follows-dose/frequency: ______
Anticipated maximum daily dose is: ______ mg per day. Anticipated duration for this medication is: ______
ALTERNATIVES: Alternatives to the use of this medication for your (or your child’s) condition include:
☐ Psychotherapy ☐ Other medication ☐ Family Therapy ☐ Group Therapy ☐ Other: ______
WITHOUT such medication, your (child’s) condition:
☐ is unlikely to improve. ☐ may or may not improve. ☐ is likely to improve.

3] NAME OF MEDICATION: ___________________ ADMINISTERED: ☐ by mouth ☐ by injection
This medication is in the class: ☐ Antipsychotic ☐ Antidepressant ☐ Mood Stabilizer
☐ Psycho-stimulant ☐ Anti-Anxiety ☐ OTHER (specify): ______
THIS MEDICATION IS INTENDED TO HELP WITH: ______
INITIAL DOSE: You (your child) will begin taking this medication as follows-dose/frequency: ______
Anticipated maximum daily dose is: ______ mg per day. Anticipated duration for this medication is: ______
ALTERNATIVES: Alternatives to the use of this medication for your (or your child’s) condition include:
☐ Psychotherapy ☐ Other medication ☐ Family Therapy ☐ Group Therapy ☐ Other: ______
WITHOUT such medication, your (child’s) condition:
☐ is unlikely to improve. ☐ may or may not improve. ☐ is likely to improve.

GENERAL PRECAUTIONS REGARDING PSYCHOTROPIC MEDICATIONS
• Avoid the use of alcoholic beverages while taking any psychiatric medication.
• All psychotropic medications, including above, may cause birth defects.
• Please inform your doctor if you are pregnant or planning to get pregnant, breastfeeding or plan to breastfeed.
• Please inform your doctor of all medicines you are currently taking (including over-the-counter & herbal).
• Keep all prescribed medicines out of the reach of children. Do not share prescribed medicines with others.
• Medication Information Sheets may not cover all uses or side effects of above medication(s).

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 consent at any time by stating my intention to any member of the treatment team.

_________________________________________  ___________________________________________
Signature of Patient/Parent/Guardian/Conservator; DATE    Signature/Licensure of Prescriber; DATE
☐ Unable to obtain Patient/Parent/Guardian/Conservator signature – SEE PROGRESS NOTE FOR EXPLANATION.