Medication Consent

The doctor/nurse has explained to me about medications that are known to be of help in treating problems such as mine. He/she has also discussed with me the likelihood of my improving or not improving without such medication. I understand that in agreeing to take medication I have not excluded other forms of treatment.

The doctor/nurse has described the medication(s) category from the group below (circle):

Anti-Psychotics/Major Tranquilizers Anti-Parkinsonian

Anxiolytics/Minor Tranquilizers Mood Stabilizers

Antidepressants Other:

The specific medication(s) discussed is/are: _____

_____

The doctor/nurse has discussed the dose & frequency of the medication(s) as well as increasing the dosage (if applicable):

Dose_____ Frequency_____

Increase (if applicable)_____

The doctor/nurse has discussed with me the possible side effects that my particular medication(s) may cause, the dangers of consuming it while under the influence of alcohol, drugs, or other sedatives/stimulants including diet pills, and side effects that may occur relative to any medical conditions I have.

I understand that if I have any questions or wish to know more about my medication I can request further information. I understand that this consent is valid for one year from this date and that I can refuse medication prescribed for me by calling the doctor or nurse to receive appropriate medical review at any time.

I have read this form, understand it, and I consent to take the medication as prescribed by the doctor/nurse.

(Print) Patient Name_____ DOB:_____

Patient Signature_____ Date_____

(Print) Physician/Nurse Name_____ Date_____

Physician/Nurse Signature_____ Date_____

A copy of this should be given to the client/patient or guardian and a copy should be kept in the medical record.)