APPENDIX R
MEDICATION TREATMENT CONSENT FORM

Consent for Treatment With

_____
(Name of Medication)

I, _____, am a patient of

Dr. _____. Dr. _____ has informed me that he/she recommends that I receive the medication _____ for the treatment of my illness. He/she has informed me of the nature of the treatment and has explained to me the risks of possible side effects, including_____

_____.

[Insert when applicable: He/she specifically discussed the risk of tardive dyskenisia, which may cause involuntary tic-like movements in the face, tongue, neck, arms, and/or legs.]

I understand that although Dr. _____ has explained the most common side effects of this treatment to me, there may be other side effects, and that I should promptly inform Dr. _____ or another member of the staff if there are any unexpected changes in my condition.

I understand that I may not be compelled to take this medication and that I may decide to stop taking it at any time.

I also understand that although Dr. _____believes that this medication will help me, there is no guarantee as to the results that may be expected.

On this basis I authorize Dr. _____ or anyone authorized by him/her to administer _____ at such intervals as he/she deems advisable.

Signed_____

Dated_____