PSYCHOTROPIC MEDICATION CONSENT FORM

Patient Name: _____ Date of Birth: _____

Purpose of Consent:

This form authorizes the administration of psychotropic medications as prescribed by the attending healthcare provider. Psychotropic medications are drugs that affect brain function, mood, and behavior. The purpose of this consent is to ensure that the patient or legal guardian understands the benefits, risks, alternatives, and rights related to these medications.

Description of Medications:

The medications prescribed may include but are not limited to antidepressants, antipsychotics, mood stabilizers, anxiolytics, and stimulants. Each medication will be explained regarding its intended effect, dosage, frequency, and potential side effects.

Risks and Side Effects:

Psychotropic medications can cause side effects that range from mild to severe, including but not limited to drowsiness, dizziness, weight changes, metabolic changes, movement disorders, mood alterations, and allergic reactions. Rarely, serious adverse effects may occur. The patient is advised to report any unusual symptoms immediately.

Alternatives to Medication:

Alternatives to psychotropic medication include psychotherapy, behavioral interventions, lifestyle changes, mindfulness, and other non-pharmacological treatments. The healthcare provider will discuss these options and their appropriateness for the patient's condition.

Patient Rights:

The patient has the right to refuse or discontinue psychotropic medication at any time, unless otherwise determined by law or court order. The patient will be informed of the consequences of refusal or discontinuation and will be provided with ongoing support and alternative treatments.

Confidentiality:

All information disclosed during treatment and related to psychotropic medication will be kept confidential in accordance with federal and state privacy laws including HIPAA, except as required by law or with the patient's written consent.

Voluntary Consent:

By signing below, the patient or legal guardian acknowledges that they have received adequate information regarding psychotropic medications, had the opportunity to ask questions, and voluntarily consent to the administration of these medications as prescribed by the healthcare provider.

Prescribing Provider Information:

Provider Name: _____

License Number: _____

I, the undersigned, affirm that I have read and understand the contents of this Psychotropic Medication Consent Form. I have had all my questions answered to my satisfaction. I consent to the use of psychotropic medication as described.

PATIENT OR LEGAL GUARDIAN SIGNATURE

Signature: _____

HEALTHCARE PROVIDER SIGNATURE

Signature: _____