CONSENT FOR TREATMENT WITH PSYCHOTROPIC MEDICATION

☐ **BCCY** ☐ **SCY** ☐ **SCYC**

Date:_____ Youth Name:_____ Client ID#:_____ DOB:_____

I, _____, am a patient of _____.
(Youth Name) *(Doctor)*

I have been informed of my illness and advised to receive the medication _____,
(Generic or trade name of medication)

which is a _____.
(Specify antipsychotic, antidepressant, mood stabilizer, anti-cholinergic)

I have been informed of the nature of the treatment and understand risks and possible side effects; including but not limited to dry mouth, excessive thirst, blurry vision, constipation, and sedation. With use of antipsychotic medication, possible side effects include tremor, muscle spasms, and restlessness. I specifically understand the risk of tardive dyskinesia, which may cause involuntary tic-like movements in my face, tongue, neck, arms and/or legs, and which may persist even after treatment with the medication has been stopped. If prescribed *Closaril*, I specifically understand the risk of agranulocytosis and the required lab work.

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

I understand that I may discontinue this medication if I choose, but I should inform my health care provider before doing so. I also understand that although my health care provider believes that this medication will help me, there is no guarantee as to the result that may be expected. I have been informed of the risk of refusing the recommended treatment. I have been informed that refusing medication does not prevent me from receiving other types of treatment.

On this basis, I authorize my health care provider or anyone authorized by my health care provider to administer the above-named medication at such intervals as deemed advisable.

SIGNATURE OF PATIENT:_____ DATE:_____

SIGNATURE OF PROVIDER:_____ DATE:_____

REFUSAL

I have been advised to take the medication(s) listed above but I am unwilling to take the medication as recommended. The possible consequences of not taking the medication have been explained to me. Specifically:

_____

_____

SIGNATURE OF PROVIDER:_____ DATE:_____

SIGNATURE OF PATIENT:_____ DATE:_____

SIGNATURE OF WITNESS:_____ DATE:_____

SIGNATURE OF 2ND WITNESS:_____ DATE:_____