

### 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 2<sup>ND</sup> WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_