



# PREMIER PSYCHIATRY

PSYCHIATRIC AND BEHAVIORAL  
HEALTH SERVICES

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## **CONSENT TO TREATMENT WITH PSYCHOTROPIC MEDICATION**

1. My doctor has explained to me that I have a mental/emotional disorder for which he is recommending psychotropic medication treatment. In the doctor's opinion, no other treatment, by itself, would currently be as effective in helping my condition.
2. I understand that the doctor is prescribing the smallest amount of medicine which, in his or her opinion, will be of help to me at this time.
3. I have been informed and given written information concerning any precautions I should take regarding activities and diet while on this medication.
4. I have been informed concerning possible side effects from taking these medications.
5. If this prescription is for major tranquilizers or neuroleptics, this medication can, in some persons, result in physical disorder of abnormal movements of the tongue, face, and extremities called Tardive Dyskinesia. I understand that this disorder may be permanent. I have been informed that my doctor and nurse will watch for any sign of this disorder.
6. I have had all questions concerning my mental/emotional disorder, and the psychotropic medications recommended for me, answered to my satisfaction at this time. I know that I can speak with my doctor or nurse concerning any other questions which I may have concerning these in the future.
7. I agree to:
  - A. Take the medication prescribed for me in the manner recommended by my doctor.
  - B. Follow the doctor's recommendation for any laboratory test which may be needed because of taking this medication.
  - C. Report any possible side effects, or unexpected reactions, as soon as possible, to my doctor, nurse, client services manager or other staff.
  - D. Tell my doctor, nurse, client services manager, if, at any time I want to stop taking these medications, and the reason for my choice.

X \_\_\_\_\_  
Signature of Patient, Parent, Guardian, or Authorized Representative

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Today's Date