CONSENT TO PSYCHOTROPIC MEDICATION

Patient Name: ________________
MRN: ___________ DOB: ________
Treatment Location: _____________

I, _______________________________________, hereby consent to and authorize the physician responsible for this care to administer the following medication for treatment of me or my _________________________ illness:
(Relationship)

____

The physician responsible for this care has informed me that the proposed medication may help to improve how I feel and/or function and the length of time that I may expect to take such medication. The physician also has informed me of the available alternatives to such medication and, as appropriate, their usual and most frequent risks and hazards.

The physician responsible for this care also has informed me of the usual and most request risks and hazards of the proposed medication, including the following common side effects:

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If the medication is a major tranquilizer, I understand that I also may experience tardive dyskinesia which causes involuntary tic-like movements in the face, tongue, neck, arms and/or legs and which may continue even after the medication is stopped.

I understand that I should immediately contact the physician responsible for this care if I experience any side effects or notice any unexpected change in my condition. Although the physician believes that this medication will help in the treatment of my illness, I further understand that it may not.

I understand that taking the prescribed medication is my choice. I may stop such medication at any time, but should inform my physician if I plan to stop. Some medications should be reduced gradually and not stopped all at once.

I further understand that if I have any additional questions regarding the prescribed medication, I may call the physician responsible for this care, the Director of the Inpatient Psychiatric Unit or Director of the Mental Health Clinic as appropriate, the Chief of Psychiatry at Maine Medical Center during business hours or call 829-1064 at other times.

__________	__________	X ______________________________	__________________
Date	Time AM|PM	Signature of ❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Representative	Printed Name
__________	__________	X ______________________________	__________________
Date	Time AM|PM	Witness Signature	Printed Name

Interpreter for: ❑ Sign Language ❑ Foreign Language ❑ Other ____

If by telephone, Consent given by: ❑ Patient ❑ Other ___________________________ ___________________________
Phone number

__________	__________	X ______________________________	__________________
Date	Time 24 Hour	Signature of Physician or Designee	Printed Name