MEDICATION CONSENT - PSYCHOTROPICS

PATIENT IDENTIFICATION STICKER (IF NEEDED)

Discussion of psychotropic medication should occur within the context of the patient(s) medical history and current overall medication regimen.

I, the undersigned, hereby authorize the professional staff of this facility to administer treatment, limited to the psychotropic medications indicated below.

MEDICATION	

I, the undersigned, acknowledge and understand the following:

- **ANTIPSYCHOTICS:** May contribute to Tardive Dyskinesia (abnormal movements) or Metabolic Syndrome.
- **ANTIDEPRESSANTS:** In patients 24 years of age or younger, antidepressants may increase the risk of suicidal thinking and behavior (suicidality) as compared to placebo.
- **FEMALE PATIENTS:** Must notify the physician if pregnant or if pregnancy is suspected.
- **MALE PATIENTS:** There is a risk of prolonged erections with Desyrel (Trazodone) Treatment.
- I have been given detailed information about 1) Proposed medications and dosage range and frequency. 2) The purpose of the treatment. 3) Common short- and long-term side effects of the proposed medication, including contraindications and clinically significant interactions with other medications.
- I have had the opportunity to ask questions and receive answers about the treatment.
- I understand that my consent may be revoked orally or in writing prior to or during the treatment period.
- I have been informed that written materials regarding the proposed treatments above are available to me upon request.

I understand that if I have additional questions about the proposed treatments above, including approximate length of care or alternate medications available for the treatment of my condition, that I may direct these questions to my physician.

Note: The patient shall always be asked to sign this authorization form. However, if the patient is incapacitated, or is incompetent to consent to treatment, the consent of his or her legal representative shall be obtained.	Signature of Patient or Legal Representative	Date	Time
	Signature of Nurse	Date	Time
	Signature of Physician	Date	Time

AHC Rev. 12.2021