

Zev S. Nathan, M.D., PH.D.
Informed Consent for Psychiatric Medications

PURPOSE OF THE FORM: THIS FORM DOCUMENTS THAT YOU AND YOUR PRESCRIBER HAVE DISCUSSED YOUR MEDICATION(S) TO YOUR SATISFACTION.

Your prescriber has ordered the following medication(s). Your prescriber has either told you about the medication(s) or given you written information or both. You are entitled to know the following information before deciding whether to take the medication(s):

1. What your condition or diagnosis is.
2. What symptoms the medication(s) should reduce and how likely the medications are to work.
3. What your chances are of getting better without the medication(s).
4. What other reasonable treatments are available.
5. The name, dosage, frequency, route of administration and duration of prescribed medications.
6. Side effects of the medications known to commonly occur.
7. Any special instructions about taking the medications.

Medication	Daily Dosage Range	notes	For modification date and pt. initials

- ◆ **By signing this form, you indicate the medications have been explained to you to your satisfaction.**
- ◆ **Even after signing, you can still refuse any dose or withdraw your agreement completely at any time.**
- ◆ **You will receive a copy of this consent form.**

Please check one of the following:

- I have had the opportunity to receive information about my medications from the prescriber, and I consent to this treatment. I understand I can ask questions about my medicines at any time. (INFORMED CONSENT).
- I have had the opportunity to discuss information about the medications with the prescriber, and I **refuse** to consent to the medications recommended. I understand that my doctor will continue to offer me the chance to take medicine, and information about it, but that I may still continue to refuse the medicine. (INFORMED REFUSAL).

The patient verbally consents to the recommended medications, but refuses to sign because:

Continued attempts to obtain signature: Initials _____ Date _____ Initials _____
Date _____

Patient Signature:	
Prescriber Name: Zev S. Nathan, M.D., PH.D.	
Prescriber Signature:	
Guardian (if patient is a minor):	

Purpose

1. To serve as a legal record of the patient's consent to take psychiatric medication as part of a treatment regimen.
2. To document that the patient has been offered information about the medications being prescribed.

Instructions

1. The patient is to receive information about the medication(s) before the form is completed.
2. This form can accommodate up to 7 medications, assuming the patient consents to all.
3. The medication(s) and dosage range(s) are entered into the table.
4. For changes in dose range or route, modifications can be made on this form by having the patient initial and date in the appropriate column. For adding new agents, a new form should be used.
5. If the patient consents to medications, check the applicable box.
 - a. If the patient agrees, then the patient and prescriber sign and date at the bottom.
 - b. If the patient cannot or will not sign, the prescriber fills in the reason, and signs at the bottom with a witness. The prescriber documents continued attempts to obtain a signature by initialing and dating the appropriate line.
 - c. If the patient is willing to document refusal of medications, this box can be checked and the prescriber and patient can sign and date at the bottom.
6. If the patient signs with a mark, a witness is needed.
7. A patient may withdraw consent at any time by notifying the prescriber. The reason for the withdrawal should be documented in the progress notes, and the medication order should be discontinued.