

PM FORM 3.15.1

Informed Consent for Psychotropic Medication Treatment

[\(Link to Spanish Version\)](#)

I have discussed the following information with my behavioral health medical practitioner for each medication listed below:

- The diagnosis and target symptoms for the medication recommended;
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects;
- The possible alternatives;
- The possible results of not taking the recommended medication;
- The possibility that my medication dose may need to be adjusted over time, in consultation with my behavioral health medical practitioner ;
- My right to actively participate in my treatment by discussing medication concerns or questions with my behavioral health medical practitioner; and
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment is required in a Court Order or in a Special Treatment Plan).

I understand the medication information that has been provided to me. By signing below I agree to the use of each medication.

Medication	Target Symptoms to be addressed*	How Discussed**	Person/Guardian Initials & Date***	Behavioral health medical practitioner Initials & Date
		<input type="checkbox"/> In-person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-medicine <input type="checkbox"/> Previously	Date: _____	Date: _____
		<input type="checkbox"/> In-person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-medicine <input type="checkbox"/> Previously	Date: _____	Date: _____
		<input type="checkbox"/> In-person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-medicine <input type="checkbox"/> Previously	Date: _____	Date: _____
		<input type="checkbox"/> In-person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-medicine <input type="checkbox"/> Previously	Date: _____	Date: _____
		<input type="checkbox"/> In-person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-medicine <input type="checkbox"/> Previously	Date: _____	Date: _____
		<input type="checkbox"/> In-person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-medicine <input type="checkbox"/> Previously	Date: _____	Date: _____
		<input type="checkbox"/> In-person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-medicine <input type="checkbox"/> Previously	Date: _____	Date: _____

Person/Guardian Printed Name

Signature

Initials

Behavioral Health Medical Practitioner Printed Name

Signature

Initials

* Target Symptoms refer to specific symptoms associated with a diagnosis, such as tearfulness, hallucinations, insomnia. List the target symptoms rather than the underlying diagnosis.

** "Previously" indicates the medication had been discussed in a previous setting (hospital, another clinic, etc.) or by another behavioral health medical practitioner and you are verifying that the person continues to consent to treatment with this medication.

*** Ensure informed consent form with original patient signature is located in patient's file. If consent obtained by telephone or through tele-medicine, individual may initial and date at next face-to-face visit.

Last Revision: 05/17/2007

Effective Date: 08/15/2007

NARBHA Revised Date: 8/27/07

Persons' Name: _____

Person's ID#: _____