ARISE BEHAVIORAL AND WELLNESS HEALTH

Psychiatric Medication Management

Medication/Treatment Consent Form

Patient:_____ **DOB:**_____

I AUTHORIZE DR. _____ OR DESIGNEE TO PRESCRIBE TREATMENTS AND PSYCHOTROPIC MEDICATIONS FOR ME. THE DOCTOR HAS EXPLAINED WHY THE TREATMENTS AND MEDICATIONS ARE RECOMMENDED AND THEIR POTENTIAL SIDE EFFECTS AND RISKS.

Alternative, available treatments and medications have been described for me along with their benefits and risks. The probable consequences of not accepting the proposed treatments and medications have been explained to me. I understand the effect of these treatments and medications are not guaranteed, and that the doctor may modify the medication dosages periodically with my consent. Off label use means medications have been approved by the FDA, but may not yet be approved for a particular condition, or above or below a certain dosage.

I understand that my consent is valid for 15(fifteen)months, until my treatment/medication changes or I am discharged from Dr. _____'s care and services, and that I may take back my consent at any time in writing. I understand that this consent form will be attached to my chart and I may receive a copy at my request.

PharmacyName:_____**PharmacyPhone#**_____

PHYSICIANS STATEMENT

I CERTIFY THAT, PRIOR TO ADMINISTERING THE FOLLOWING MEDICATION(S), OR AS SOON AS CLINICALLY FEASIBLE THEREAFTER, I DISCUSSED THEIR RISKS AND BENEFITS WITH THE ABOVE NAMED PATIENT. I HAVE EXPLAINED THE AVAILABLE ALTERNATIVES TO THESE MEDICATIONS.

MEDICATION NAME	MEDICATION DOSE RANGE	MD INITIALS

_____

Provider's signature_____ Date_____

Patient's signature_____ Date_____

Signature of Person legally authorized to Consent for Patient:

_____

Printed name of Person legally authorized to Consent for Patient:

_____ Reason/Relationship_____