**TARZANA TREATMENT CENTERS, INC.**

VOLUNTARY PATIENT CONSENT FOR USE OF ANTIPSYCHOTIC, ANTIDEPRESSANT, AND OTHER MEDICATIONS

## Medical Services

This form is intended to set out the nature of the information your physician will provide you regarding your treatment with certain medications*.* ***Read this form thoroughly before you sign it, and if you cannot read well, ask to have this form read to you.***

My physician has discussed the following information with me:

1. The nature of my mental condition.
2. The reasons for taking such medication including the likelihood of my improving or not improving without such medication. I have been informed when I may expect to see beneficial effects from the medication.
3. The reasonable alternative treatments available, if any.
4. The type, range, frequency, and amount (including use of prn orders), method (oral or injection), and duration of taking the medications.
5. The possible side effects of these drugs known to commonly occur and any particular side effects more likely to occur based upon my particular condition and my health history (be sure to tell your doctor of any medication you may be taking, or any allergies you have or if you think you may be pregnant) which include:
6. The possible side effects, which may occur if I take certain medications for more than three months. These side effects may include persistent involuntary movements of the face or mouth and might, at times, include similar movements of the hands and feet. These symptoms of tardive dyskinesia are potentially irreversible and may appear after the medication has been discontinued.
7. I have the right to accept or refuse this type of treatment and my consent may be withdrawn at any time by stating my desire to any member of the treatment staff.
8. I understand that even without my consent, in the event of an emergency (preservation of life or prevention of bodily harm to myself or others) such medication can be administered to me to relieve that emergency.

I have read the above information and have discussed it with my physician.

I understand this information and I have no further questions at this time.

I understand that if I have questions after I have taken this medication I will have an opportunity to discuss them with my physician.

I hereby consent to the administration of the following medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ within these ranges \_\_\_\_\_\_\_\_\_ mg.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ within these ranges \_\_\_\_\_\_\_\_\_ mg.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ within these ranges \_\_\_\_\_\_\_\_\_ mg.

|  |  |
| --- | --- |
|  |  |
| ***Patient’s Signature*** | ***Date*** |

|  |  |
| --- | --- |
|  |  |
| ***Parent or Guardian’s Signature (if required)*** | ***Date*** |

Person Obtaining Consent (Physician or Nurse) [Print Name and Title and Sign Below]:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Name Title***

|  |  |
| --- | --- |
|  |  |
| ***Person Obtaining Consent’s Signature*** | ***Date*** |

To be completed by physician only if patient chooses not to sign form:

I have presented this form and discussed its contents and the proposed medication with

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. He/she understands the nature and effects ***Patient's Name***

of the medication and consents to taking such medication but does not wish to sign this form.

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 ***Physician’s Signature Date***