CONFIDENTIAL PATIENT INFORMATION
California W&I Code, Section 5328

COUNTY OF ORANGE, CALIFORNIA
HEALTH CARE AGENCY
BEHAVIORAL HEALTH SERVICES
PSYCHOTROPIC MEDICATION CONSENT

Patient Identification

My physician and I discussed:

1. The nature of my mental condition.
2. My physician's reasons for prescribing the medication, including the likelihood of my condition improving or not improving without the medicine.
3. I can refuse to take any medication at any time, but it is recommended that I discuss my decision with my physician before I stop taking any medication.
4. Reasonable alternative treatments available for my condition.
5. The type of medication that I will be receiving, the frequency and range of dosages, the method by which I will take the medication, and the duration of such treatment.
6. The common side effects of this medication, and any particular side effects likely to affect me.
7. That certain antipsychotic medications may cause additional side effects for some persons, including tardive dyskinesia. Tardive dyskinesia is defined as persistent involuntary movements of the face, mouth, torso, hands, or feet. These symptoms are potentially irreversible, and may continue after the antipsychotic medication has been stopped.

I was given information about the recommended medication. I understand that the information does not cover everything, but it includes items of clinical significance to me. I should discuss all my medical problems and any medication that I take with my physician(s). For more information I may refer to a pharmacist or to a standard text such as the Physician's Desk Reference (PDR).

I have received the information about the psychotropic medication by means of: (Check those that apply)

☐ Oral Explanation ☐ Printed Material ☐ Video Presentation ☐ Other

Name of Medication (Generic name is acceptable. Include anticipated dosage range.):

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I understand I have the right to refuse this medication, and that it cannot be given to me until I have spoken with my physician and given consent to it, except in an emergency. I understand and give consent to the medication listed above, which is an FDA approved medication, although its use in my condition(s) may not always appear as part of its approved labeling.

Client/Parent/Guardian signature ______________________________ Date ____________

Physician signature ______________________________ Date ____________