FRESNO COUNTY MENTAL HEALTH
INFORMED MEDICATION CONSENT
FOR ADULTS AND CHILDREN

This is to acknowledge that I have had a discussion with my/ my child's provider, concerning my/ his/her prescription of the following medication(s) to treat the following symptoms: _____

Medications	Type	Dosage or Starting Dose	Maximum Dosage Range as prescribed	Frequency	Route	Duration

I have been informed and understand the **commonly occurring** side effects, and that there may also be other less common ones but not limited to those listed below. These side effects may be experienced at any point in time while taking these medications and may exceed 3 months after medication has been discontinued.

- ☐ Drowsiness/Sedation/Sleep disturbances
- ☐ Dark Urine/Trouble with urination
- ☐ Muscle stiffness/ Tremor/Restlessness
- ☐ Sexual Problems
- ☐ Pregnancy Issues (incl. birth defects)
- ☐ Blurred Vision/Dizziness
- ☐ Diarrhea/Constipation/Nausea
- ☐ Increased Blood Glucose levels
- ☐ Rash/Itchy Skin
- ☐ Fatigue/Tiredness
- ☐ Cardiac Irregularities
- ☐ Appetite &/or weight changes
- ☐ Trouble with Concentration
- ☐ Headaches
- ☐ Abnormal internal bleeding
- ☐ Tardive Dyskinesia: Involuntary movement of tongue, face, neck, limbs or torso.
- ☐ Suicidal thoughts **(Black Box Warning)**
- ☐ Neuroleptic Malignant Syndrome: Fever, lead-pipe stiff muscles, confusion, fast heart, tremor, agitation, excess sweat
- ☐ Serotonin Syndrome: Headache, nausea/vomiting, loud bowel sounds, twitching muscles, heavy sweating, dilated pupils
- ☐ Other comments/additional side effects: _____

_____

- ☐ **Alternative Treatments Available:** _____
- ☐ **Off label Use**_____

☐ This form was interpreted in _____for me by_____

If a translated version of this Form was signed by the client and/or guardian, attach translated version to the English version.

☐ I was offered printed materials in my preferred language on my current medications, dosages and side effects.

I understand that the decision to take any medication is solely up to me, and I understand the potential risks and benefits of the medication(s) listed on this form as they've been explained to me. I may withdraw my consent for any medication at any time by signing a Medication Consent Withdraw form for that medication(s). I know I should always first discuss with my psychiatric prescriber any decision to increase, decrease, or to abruptly stop taking any medications and any decision by myself or any other provider to add or remove a medication that my psychiatric provider didn't know about when I consented for the medication(s) listed on this form. It is my responsibility to keep my psychiatric provider updated on any medications I take from any source. I understand that my psychiatric provider believes the medication(s) listed on this form and used by me only as prescribed will help me, but I know there is no guarantee as to the results.

Signature:_____ **Date:** _____

Client/Parent/Legal Guardian

☐ Copy given ☐ Copy refused ☐ Refused to sign but willing to take medications.

I have explained the benefits, risks and alternative therapies as well as side effects of the medication listed above and have obtained the clients/responsible adult's informed consent.

Signature: _____ **Date:** _____

Psychiatrist/NP/PA

Rev 3/28/17