psychiatrie.me

PSYCHOTROPIC MEDICATION CONSENT

I, _____, hereby consent to and authorize my physician to prescribe and supervise the following
(name)

psychotropic medication _____,
(medication)

for the treatment of _____.
(condition)

The physician responsible for my care has informed me that the aforementioned medication may help to improve how I feel and/or function, as well as the length of time that I may expect to take such medication. My physician has also informed me of the available alternatives to such medication and, as appropriate, their usual and most frequent side effects, risks, and hazards. Additionally, we have reviewed any relevant monitoring that may be indicated with the use of the proposed medication.

The physician responsible for my care has also informed me of rare and potentially serious side effects of the medication, including, where applicable, suicidal ideation, cardiac arrhythmia, seizure, sedation, respiratory depression, permanent movement disorder, blood dyscrasia, hepatic injury, renal insufficiency, thyroid dysfunction, severe rash, metabolic syndrome, syncope, and electrolyte derangement.

Where applicable, I understand that if I am pregnant, become pregnant, or plan to become pregnant that I will immediately notify my physician given the potential for harm that the proposed medication may have to a developing fetus.

I understand that I should immediately contact my physician if I experience any side effects or notice any unexpected change in my condition. While my physician believes that this medication will help in the treatment of my illness, I further understand that it may not, and psychiatric symptoms may paradoxically worsen with introduction of the proposed medication.

I understand that taking the prescribed medication is my choice. I may stop such medication at any time, but will inform my physician if I plan to stop. I also understand that some psychotropic medications should be reduced gradually and not stopped all at once.

It is my further understanding that if I have additional questions regarding the prescribed medication, I may call my physician.

_____ _____ _____
Signature of Patient | Printed Name of Patient | Date

_____ _____
Physician Signature | Date

Andrés Abreu, MD
Psychotherapy & Psychopharmacology
PO Box 1198 Southwest Harbor, ME 04679
207.200.8330 psychiatrie.me
ME | VT | MA | NH