Penn Psychiatric Center

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Informed Consent for Medications

Name: (Last Name:) (First Name) (MI)

Dr. _____ outlined that medication, in conjunction with therapy, may be the most effective course of treatment for my symptoms and would include the use of psychotropic medications. These are medications that are used to treat mental and emotional challenges (illness).

I understand Penn Psychiatric Center has a conservative policy regarding the prescription of controlled substances. We do not continue prescriptions of controlled substances begun by other doctors. We support the long-term health of our patients by committing to medications and therapies with a low potential for problematic use. We are happy to transition you from any controlled medications to non-controlled alternatives in the first session.

I understand that my prescriber has given me information regarding the risks, benefits, and potential side effects of the medications he is prescribing to me. I understand that at any time I may request additional information from my Doctor, Nurse, or the Pharmacist at my pharmacy of choice. During my ongoing medication appointments with my Doctor I will have the opportunity to further my knowledge by discussing my particular success and challenges with the medications I am being prescribed.

I understand that the medication(s) I may be prescribed have been successful in treating others with similar symptoms; however there is no guarantee that the medication(s) will be as effective with my particular symptoms. I agree to notify my Doctor in the event that I experience any side effects or problems with my medication(s).

I understand that if my Doctor requires me to see a therapist and I discontinue receiving individual therapy, do not have an updated treatment plan with my therapist, or have not seen my individual therapist for more than 30 days, I may no longer receive medication services from my Doctor at Penn Psychiatric Center, Inc. In such cases, I may be discharged from services for up to one year or longer based on the number of missed/cancelled appointments. If I am permitted to return I must first complete an Intake & Assessment Session prior to seeing my Doctor to continue medications.

I have informed my doctor that I am: Please check one: **Pregnant** **Not Pregnant** **Not Applicable**

Should I become pregnant while taking medications, I agree to inform the doctor as soon as possible for my continued safe care.

I voluntarily consent to take the medication(s) being prescribed by my Doctor (if applicable). I understand that I have the right to choose not to take medication as part of my recovery. I understand that I have the right to withdraw my consent and stop taking medication(s) at any time. However, it is my responsibility to contact my doctor immediately in order to learn how to safely discontinue the medication(s) prescribed.

Client/Parent/Guardian Signature: _____ Date: _____

As a physician, I certify that these instructions have been disclosed to the client/parent/guardian, if appropriate and they expressed understanding and agreed to take the medications:

Physician Signature: _____ Date: _____