San Luis Obispo County Behavioral Health Department
INFORMED CONSENT FOR MEDICATION

Your attending doctor/nurse practitioner has recommended that you be treated with the following medication(s):

THERAPEUTIC CLASS:

☐ Antipsychotic ☐ Antidepressant ☐ Mood Stabilizer ☐ Anxiolytics ☐ Hypnotics ☐ Stimulant
☐ Anticholinergic
☐ Medication Assisted Treatment Medications ☐ Other

☐ Buprenorphine with or without Naloxone

☐ Naltrexone
☐ Vivitrol
☐ Antabuse

Click the CURES link (BELOW), if you selected any of the following options above:

Anxiolytic, Hypnotics, or Stimulant.

☐ Other:_____

You consent to the following medications:

Please enter medication/s below (name, dose, and FDA dose range)

It will be administered ☐ Oral ☐ Injection ☐ Transdermal (Patch) ☐ Intranasally
☐ Sublingual (Under Tongue)

(Times per day maybe adjusted up or down as needed or clinically indicated)

Initial length of treatment is: months and may be continued if clinically indicated or patient desires.

Periodic laboratory monitoring/blood levels may be required.

☐ Medication selected will be given for off label use:

Indication for off label use:

☐ Indication medication over recommended FDA limit

Medication: FDA Approved Range: Dose Prescribing:

Justification for use over FDA approved range:

SIDE EFFECTS:

All medications may cause undesired effects as well as desired effects. Many side effects are mild. If side effects do occur, they may go away or lessen during treatment. Certain side effects are more common with some medications and less likely with others. Side effects are usually dose dependent (more side effects with higher dose, less with lower dose). If you experience and unusual or distressing side effects or feel you cannot continue taking your medication, please report to your prescriber or a member of your mental health treatment team as soon as possible.
You will find a more detailed list of side effects on the leaflets that I will provide to you.

Your signature constitutes your acknowledgement

1. that you have read or have had read to you, and agree to the above-mentioned;
2. that the medications listed above have been adequately explained and/or discussed with you by your prescriber, and that you have received all the information you desire concerning such medication and treatment; and
3. that you authorize and consent to the prescribing and administration of such medication and treatment.

You acknowledge that you have read or have had read to you the description of the medication your prescriber has prescribed. You have had the opportunity to have your questions answered. You are aware of the benefits, side effects and alternatives to the prescribed therapy and consent to take this medication.

You understand your name will be checked and/or added into the Controlled Substance Utilization Review and Evaluation System electronic database that is maintained by the Department of Justice if you are prescribed any controlled substances listed as Schedule II, Schedule III, or Schedule IV.

☐ You understand that if you abruptly stop the medication treatment, that you may experience adverse symptoms such as negative mood change as withdrawal

☐ You understand that if you self-administer Buprenorphine/Suboxone, that you may experience precipitated withdrawal and this has been explained to you by your prescriber and members of the treatment team

☐ You understand that if you self-administer Naloxone and you have recently taken an opiate, that you may experience opiate withdrawal

☐ You understand that if you drink alcohol while taking Antabuse/Disulfiram, that you will experience adverse symptoms

You understand that you have the right to revoke this consent at any time by stating such intention to any member of the treatment staff except if you are conserved under LPS Conservatorship or are Court-ordered to be on psychotropic medication.

☐ Patient was offered a copy of this consent

☐ Received ☐ Declined

☐ Patient was provided educational material which discusses this medication to the patient and/or parent/legally responsible person.

☐ Received ☐ Declined

☐ I discussed the following information about this medication with the patient and/or parent/legally responsible person in a manner understandable to him/her.

1. The reasons for prescribing the medication (including the illness/condition being treated).
2. The purpose and expected results of this medication.
3. The potential side effects of the medication.
4. Possible additional side effects which may occur if taken beyond three (3) months.
5. The type, frequency and dose of the medication, including the length of time the medication needs to be taken.
6. Alternative treatments and/or medications (including no treatment and its consequences).
7. The potential need for initial/periodic laboratory tests and medical consultations with the patient's primary care physician.
8. I have checked the system and/or updated patient information as required by law.
9. I have provided the patient a copy of the medication consent and written information on the medication(s) as requested.

Signatures

Signature	Signature Line Heading	Printed Name	Date
	☐ Client		
	☐ Rep./Legally Resp. Person		
	☐ MD/DO/NP		