MEDICATION CONSENT FORM
ALAMEDA COUNTY
BEHAVIORAL HEALTH CARE SERVICES

NAME:

DOB

PSP#

SS#

I understand that I have the right to refuse this medication, and that it cannot be administered to me until I have spoken with my physician and given consent to it, except in an emergency. My physician and I discussed:

1. **The nature of my mental condition.**
2. **The reasons** that my physician has for prescribing the medication, including the likelihood of my condition improving or not improving without the medicine.
3. **I can refuse to take the medication** at any time if I tell any member of the treating staff.
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 (shots or mouth), and **duration** of such treatment.
6. The side effects of these drugs known to commonly occur, and any particular side effects likely to occur in my particular case.
7. The possible additional side effects which may occur if I take the medication beyond three months, including **tardive dyskinesia** which is persistent involuntary movements of the face, mouth, hands or feet. Certain antipsychotic medications can cause these symptoms which are potentially irreversible, and may appear after the medications have been discontinued.

I was also given specific written information about the recommended medication. I understand that this is only a partial listing of information, and I should discuss all my medical problems and any medication that I take with my physician(s).

[ ] Antianxiety Agents, specifically ____________________

[ ] Antidepressants, specifically ____________________

[ ] Antipsychotics, specifically ____________________

[ ] Mood Stabilizers, specifically ____________________

[ ] Psychostimulants, specifically ____________________

[ ] Sedative/hypnotics, specifically ____________________

[ ] Other: ____________________

[ ] I understand that the medications listed below are FDA approved medications although their use in my condition(s) does not appear as part of their approved labeling.

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Date ____________ Patient/Parent signature ____________________

Date ____________ Physician signature ____________________

[ ] Pt. agrees, but chooses NOT to sign. Staff: ____________________ DATE ____________

[ ] Pt. on conservatorship, Conservator sig:____________________ DATE ____________