

This form provides information regarding recommended medications(s) to support a client's mental health and is not a contract to force medication use against a client's will. This form may not cover all the uses or possible side effects of a client's treatment.

Client name: _____ DOB: _____ PSP: _____

1. Medications are recommended for treating bothersome symptoms. The following symptom(s) I am experiencing is/are the reason(s) my medication(s) is/are recommended for me:

- | | | |
|--|---|--|
| <input type="checkbox"/> Lack of energy or motivation | <input type="checkbox"/> Aggression or hostility | <input type="checkbox"/> Difficulty organizing thoughts |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Difficulty communicating well with others |
| <input type="checkbox"/> Poor appetite or over eating | <input type="checkbox"/> Rapid thoughts | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Difficulty concentrating or easily confused | <input type="checkbox"/> Impulsive behaviors | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Difficulty sleeping or sleeping too much | <input type="checkbox"/> Unwanted thoughts | <input type="checkbox"/> Nightmares or flashbacks |
| <input type="checkbox"/> Anxiety or constant worrying | <input type="checkbox"/> Fixed beliefs | <input type="checkbox"/> Muscle stiffness or spasms |
| <input type="checkbox"/> Difficulty coping with stress | <input type="checkbox"/> Fearful feelings or unrealistic fears | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Irritability or agitation | <input type="checkbox"/> Visions or voices others can't see or hear | <input type="checkbox"/> Other: _____ |

Medication Name	Medication Type (Class of Med)	Administered by (Route):	Daily Dose (Range):	Frequency (Range):
	<input type="checkbox"/> Antidepressant <input type="checkbox"/> Anti-Anxiety <input type="checkbox"/> Antipsychotic <input type="checkbox"/> Mood Stabilizer <input type="checkbox"/> Psychostimulant <input type="checkbox"/> Anti-EPSE <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Mouth <input type="checkbox"/> Injection <input type="checkbox"/> Other (specify):		
	<input type="checkbox"/> Antidepressant <input type="checkbox"/> Anti-Anxiety <input type="checkbox"/> Antipsychotic <input type="checkbox"/> Mood Stabilizer <input type="checkbox"/> Psychostimulant <input type="checkbox"/> Anti-EPSE <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Mouth <input type="checkbox"/> Injection <input type="checkbox"/> Other (specify):		
	<input type="checkbox"/> Antidepressant <input type="checkbox"/> Anti-Anxiety <input type="checkbox"/> Antipsychotic <input type="checkbox"/> Mood Stabilizer <input type="checkbox"/> Psychostimulant <input type="checkbox"/> Anti-EPSE <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Mouth <input type="checkbox"/> Injection <input type="checkbox"/> Other (specify):		
	<input type="checkbox"/> Antidepressant <input type="checkbox"/> Anti-Anxiety <input type="checkbox"/> Antipsychotic <input type="checkbox"/> Mood Stabilizer <input type="checkbox"/> Psychostimulant <input type="checkbox"/> Anti-EPSE <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Mouth <input type="checkbox"/> Injection <input type="checkbox"/> Other (specify):		
	<input type="checkbox"/> Antidepressant <input type="checkbox"/> Anti-Anxiety <input type="checkbox"/> Antipsychotic <input type="checkbox"/> Mood Stabilizer <input type="checkbox"/> Psychostimulant <input type="checkbox"/> Anti-EPSE <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Mouth <input type="checkbox"/> Injection <input type="checkbox"/> Other (specify):		

2. My need for this medication will be evaluated every visit. It is common to continue taking medications after the symptoms have gone away to prevent the symptoms from coming back. It is estimated that I will be prescribed these medications for at least:

- 6 months or longer 12 months or longer Other: _____

3. Additional and alternative treatment options deemed reasonable for my condition include:

- Psychotherapy Group or family therapy Other medications Other: _____

4. Side effects, including probable and possible long-term (more than 3 months) side effects, are listed on the back of this form or provided separately.

5. I have been offered and discussed medication information to my satisfaction and understand the importance of:

- Talking to my prescriber if I wish to stop medications in order to discuss the possible effects from stopping medications,
- Lab tests or other assessments performed at least once a year to monitor my progress and risk of experiencing side effects,
- Talking to my prescriber if I plan to or become pregnant or breast feed as many medications can cause birth defects.

6. I have been offered a copy of this medication consent form and understand I have the right to ask for additional medication information, refuse to take medication(s) and I may withdraw this consent at any time.

Client's or Substitute Decision Maker's Signature:	Relationship to Client:	Date:
Prescriber's Signature:	<input type="checkbox"/> Psychiatrist (MD/DO) <input type="checkbox"/> Psychiatric Nurse Practitioner (PNP) <input type="checkbox"/> Physician Assistant (PA)	Date:
Staff Witness (if patient agrees but chooses not to sign):		Date:

This is not a complete list of the possible side effects and risks associated with each medication. Consult a healthcare professional to obtain additional information. Talk to your prescriber about ways to prevent or manage all side effects.

Common Side Effects for All	How to Prevent or Manage Probable Side Effects
Upset Stomach	Take the medication with food unless directed otherwise by your prescriber
Constipation or diarrhea	Drink plenty of water, exercise, and eat foods high in fiber (ex: fruits and veggies, whole grains, oatmeal, and others)
Dry mouth	Drink plenty of water, eat a healthy snack or occasionally suck on a sugar-free candy
Drowsiness/fatigue	Ask your prescriber if it is okay to take your medication(s) at bedtime
Headache	Usually goes away within a few days. Drink water and talk to your prescriber if the headache does not go away

Medication or Class	Probable Side Effects	Possible Long-Term Side Effects (More than 3 months)
<input type="checkbox"/> Antipsychotics	Muscle spasms, restlessness, weight gain, increase blood sugar or cholesterol Females: Increases a hormone that can lead to missed menstrual cycle or milk production Males: Increases a hormone that can lead to increased fat tissue around breast or decreased desire for sex	Repeated movements of muscles of the face, mouth, arms, legs or torso and may appear after the antipsychotic is stopped
<input type="checkbox"/> Antidepressants	Temporary jittery feeling when first started or with a dose increase If stopped suddenly: flu-like symptoms, brain zaps or shock-like feelings	Males: delayed ejaculation Females: difficulty having an orgasm
<input type="checkbox"/> Mood Stabilizers o Valproate derivatives o Carbamazepine o Oxcarbazepine o Lamotrigine	Rash, dizziness, unsteadiness, blurred or double vision, weight gain	Abnormal blood counts or sodium, missed menstrual cycle, hair loss or increased body hair.
<input type="checkbox"/> Mood Stabilizers o Lithium	Increased thirst and urination, acne, tremor	Lowers thyroid or kidney function
<input type="checkbox"/> Psychostimulant	Fast heartbeat, anxiety, reduced appetite, weight loss, irritability, trouble falling asleep	Delayed growth, lower sex drive
<input type="checkbox"/> Sleep, Anti-Anxiety, or Anti-EPSE Agents		
o Benzodiazepine o Nonbenzodiazepine (Z-drug)	Weakness or fatigue, unsteadiness, dizziness, hang over effects, risk of falls, unusual dreams, sleep eating or driving	Memory difficulties, habit forming
o Buspirone	Dizziness, jittery or restless feeling, difficulty sleeping, confusion, blurred vision	Well tolerated
o Gabapentin o Pregabalin	Fatigue, dizziness, blurred vision	Weight change, leg swelling
o Hydroxyzine o Diphenhydramine o Benzotropine	Dizziness, fatigue, sleepiness, difficulty concentrating, blurred or double vision, difficulty urinating	Memory difficulties or clouded thoughts
o Propranolol	Fatigue, dizziness, lowers blood pressure and heart rate	Lower blood pressure and heart rate

<input type="checkbox"/> Other Medication Additional Medication Information Sheets Offered? <input type="checkbox"/> Yes, provided to client <input type="checkbox"/> Yes, client declined		
Medication names:	Probable Side Effects	Possible Long-Term Side Effects (More than 3 months)

Client's Initials or Substitute Decision Maker:	Prescriber's Initials:
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