GRACEMEDICAL
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Informed Consent for Psychiatric Medications

Your doctor has prescribed the following medication(s) and should have either told you about the medication(s) or given you written information, or both. You are entitled to the following information before deciding whether or not to take the medication(s):

1. Your condition or diagnosis.
2. Symptoms that the medication is expected to reduce, and how effective the medication is expected to be.
3. Likelihood you will improve without medication.
4. Whether or not other reasonable treatments are available.
5. Medication name, dosage, frequency, and route of administration, and expected duration of use.
6. Common medication side effects, as well as rare potentially life-threatening side effects, as well as fetal risk in pregnant women.
7. Information about the association of certain medications with tardive dyskinesia (persistent involuntary movement of the face or mouth and possibly similar movement of the hands and feet), which is potentially irreversible and may appear after medications have been discontinued.
8. Any special instructions about taking the medications.

Purpose: This form documents that you and your prescriber have discussed your medication(s) to your satisfaction.

Medication	Daily Dose Range	For Modification: Date/Patient Initials

- **By signing this form, you indicate the medications have been explained to you to your satisfaction.**
- **Even after signing, you can still refuse any dose or withdraw your agreement completely at any time.**
- **You may request a copy of this consent form at any time.**

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Please check one of the following:

☐ I have received information about my medications from the prescriber, and I consent to this treatment. I understand I can ask questions about my medicines at any time (INFORMED CONSENT). I agree not to change the medication(s) dosage without first consulting with the prescriber. I was advised to discuss drug interactions and special instructions with the dispensing pharmacist.

☐ I have had the opportunity to discuss information about the medications with the prescriber, and I **refuse** to consent to the medications recommended. I understand that my doctor will continue to offer me the chance to take medicine, and information about it, but that I may still continue to refuse the medicine (INFORMED REFUSAL).

☐ The patient verbally consents to the recommended medications, but refuses to sign because: _____

☐ The patient *does* not verbally consent to the recommended medications, and refuses to sign because: _____

☐ Conservator / guardian consulted with the prescriber via telephone and consents to this medication treatment plan.

Continued attempts to obtain signature:

Initials_____ Date _____ Initials_____ Date _____

Prescriber Name (Print): _____

Signature: ***Date***

Patient _____ _____

Prescriber _____ _____

Witness* _____ _____

** If patient is not able or willing to sign*