PM FORM 3.15.1

Informed Consent for Psychotropic Medication Treatment

(Link to Spanish Version)

I have discussed the following information with my behavioral health medical practitioner for each medication listed below:

- The diagnosis and target symptoms for the medication recommended;
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects;
- The possible alternatives;
- The possible results of not taking the recommended medication;
- The possibility that my medication dose may need to be adjusted over time, in consultation with my behavioral health medical practitioner ;
- My right to actively participate in my treatment by discussing medication concerns or questions with my behavioral health medical practitioner; and
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment is required in a Court Order or in a Special Treatment Plan).

I understand the medication information that has been provided to me. By signing below I agree to the use of each medication.

Medication	Target Symptoms to be addressed*	How Discussed**	Person/Guardian Initials & Date***	Behavioral health medical practitioner Initials & Date
		❑ In-person ❑ Telephone ❑ Tele-medicine ❑ Previously	Date: ____________	Date: ____________
		❑ In-person ❑ Telephone ❑ Tele-medicine ❑ Previously	Date: ____________	Date: ____________
		❑ In-person ❑ Telephone ❑ Tele-medicine ❑ Previously	Date: ____________	Date: ____________
		❑ In-person ❑ Telephone ❑ Tele-medicine ❑ Previously	Date: ____________	Date: ____________
		❑ In-person ❑ Telephone ❑ Tele-medicine ❑ Previously	Date: ____________	Date: ____________
		❑ In-person ❑ Telephone ❑ Tele-medicine ❑ Previously	Date: ____________	Date: ____________
		❑ In-person ❑ Telephone ❑ Tele-medicine ❑ Previously	Date: ____________	Date: ____________

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Person/Guardian Printed Name **Signature** **Initials**

______________________________ ______________________ ______

Behavioral Health Medical Practitioner Printed Name **Signature** **Initials**

* Target Symptoms refer to specific symptoms associated with a diagnosis, such as tearfulness, hallucinations, insomnia. List the target symptoms rather than the underlying diagnosis.

** "Previously" indicates the medication had been discussed in a previous setting (hospital, another clinic, etc.) or by another behavioral health medical practitioner and you are verifying that the person continues to consent to treatment with this medication.

*** Ensure informed consent form with original patient signature is located in patient's file. If consent obtained by telephone or through tele-medicine, individual may initial and date at next face-to-face visit.

Persons' Name: ______________________

Person's ID#: ______________________