Child & Adolescent
Psychiatric Services of Maine

Patient's Name: _____

Date of Birth: _____

Today's Date: _____

CONSENT TO PSYCHOTROPIC MEDICATION

I hereby consent to and authorize the physician responsible for this care to administer the following

medication(s) for the treatment of my or my child's (Diagnosis/es)_____

with the following medication(s): _____

The physician responsible for this care has informed me of the nature of and reason for the proposed treatment, its expected duration as well as the available alternatives to such medication and, as appropriate, their usual and most frequent risks and hazards of the proposed treatment, including the common side effects associated with the prescribed medication. A list of side effects including Serious and Common Reactions was provided to you and reviewed on initiation of the medication trial. If not, please inform the provider and arrange to discuss the adverse reactions associated with this medication trial.

I understand that I should immediately contact the physician responsible for this care if I experience any side effects or notice any unexpected changes in my condition. Although the physician responsible for this care believes that this medication will assist in the treatment of my illness, I further understand that there is no guarantee as to the results that may be expected from such treatment.

It is my understanding that I may not be compelled by the physician responsible for this care to take the prescribed medication and that I may discontinue it at any time. It is my further understanding that if I have any additional questions regarding the prescribed medication, I may call the prescriber of the medication.

I have been offered additional printed information on this medication. I Declined / Accepted

_____ _____ _____ _____

Treatment Provider Date Patient or Signature of Minor **Age 14 or Older** Date

_____ _____

Authorized Representative if Patient is **under Age 14** Date