CONSENT FORM FOR PSYCHIATRIC TREATMENT

Name: _________________________________________                        Date: _____________

MR #: _______________________________________

Introduction: This form is to be completed and signed by an authorized prescribing clinician and by the client,
or by the guardian with appropriate authority of an incompetent client, or by the parent/guardian with
appropriate authority of a minor child for whom psychiatric treatment is being recommended.

My authorized prescribing clinician met with me and we talked about: a) condition(s), for which treatment is
being recommended; b) recommended treatment; c) dosage of medication, and how I will take it (by mouth or
injection); d) duration of treatment (no more than one year at a time); e) desirable outcomes of the proposed
treatment (prognosis with treatment); f) risks, benefits and side effects of the treatment; g) dangers of abruptly
discontinuing medications and how to safely discontinue medications; h) feasible alternative treatments,
including benefits, risks, and probable effectiveness of each; and i) possible outcomes if no treatment is
received. I received written information about the proposed treatment, side effect profile and accepted the
following treatment:

Name of Medication ______________________________________________

For ____________________________________________________________

I understand I have the right to revoke my consent or refusal to any treatment at any time.

Client Signature: _________________________________________________    Date: _______________

Guardian/Parent Signature: _________________________________________  Date: _______________

Authorized Prescribing Clinician Signature: _____________________________  Date: _______________