INFORMATION AND CONSENT FOR PSYCHOACTIVE MEDICATION
Denton County MHMR

Individual Name: _____ Case #: _____
Date: _____ Medicaid #: See Fee Assessment/Record

YOU HAVE BEEN PRESCRIBED THE FOLLOWING MEDICATION

_____ _____ _____
_____ _____ _____

- This medication is for a chronic condition and you may be on it for a long time. Medication is not a cure but can improve the quality of your life by decreasing or stopping the symptoms of your illness.
- Like every medication, side effects may occur. These are usually mild and will often decrease or stop as your body gets adjusted to the medication. If side effects become too unpleasant or you are concerned that it may endanger your health, your psychiatrist will adjust or stop the medication. We will try to adjust your medication so that the benefits of treatment outweigh the side effects.
- Side effects vary greatly from one person to the next. Some people do not experience side effects. It is your responsibility to notify the nurse or psychiatrist as soon as you think that you are experiencing a serious side effect.
- There may be increased risks of suicidal thoughts or actions in some children, teenagers, and young adults within the first few months of treatment with an antidepressant. Depression and other serious mental illnesses are the most important causes of suicidal thoughts and actions.

Things That You Should NOT DO While Taking This Medication (s)

1. DO NOT drink alcoholic beverages or take street drugs.
2. DO NOT mix with other drugs or herbal remedies unless you have discussed it with your doctor.
3. DO NOT drive if this or any other medication makes you drowsy.
4. DO NOT change the dose or schedule of the medication without your psychiatrist's approval or unless the medication is causing you a serious problem. If you discontinue your medication, your symptoms could return or you could have other serious side effects.

You are recommended to obtain a Physical Examination at least once a year.

By signing below I am in agreement with the following statements and that I have been given written and verbal information on this medication:

1. I have been given education and information regarding my diagnosed mental disorder.
2. I have been given education and information regarding the medication (s) prescribed to me for my diagnosed mental disorder. The information that was given to me included the risks, benefits and side effects of the medication (s) as well as alternative treatments for the disorder.
3. I agree to provide my doctor with information on all of the prescription, herbal and over the counter medications that I take.
4. I agree to provide my doctor information on any past medication allergies or reactions to medications as well as past and current medical problems.
5. I have read the above information, or it was read to me. I consent to take this medication (s).
6. I understand that I am responsible for getting blood work or other tests done as requested by my psychiatrist. I understand that these tests are a necessary part of my treatment and are for my protection.
7. I understand that I may ask my psychiatrist or RN for more information regarding this medication at any time and that I may withdraw my consent at any time.

Individual or Guardian: _____ Date: _____
Registered Nurse: _____ Date: _____
Physician / APN: _____ Date: _____

Staff signature, credentials and printed name. If RN Signs the Physician must sign within two working days.

MD 39/41 03/08 RV: 9/08
File under Medical, on top of the Evaluation. EX:

INFORMATION AND CONSENT FOR PSYCHOACTIVE MEDICATION
Denton County MHMR

INDIVIDUAL/GUARDIAN TO SIGN IN THE APPROPRIATE BOX FOR CONSENT TO TREATMENT

ANTIPSYCHOTIC DRUG THERAPY CONSENT

1 To treat my mental disorder, the doctor recommends that I take, and continue to take, _____ an antipsychotic drug. I have been informed that in the doctor's opinion, this is the most effective available therapy in improving/preventing a relapse of my mental disorder.
2. I understand that, if I continue drug therapy, I could develop involuntary movements of my mouth, tongue, and/or other body parts and that in almost all cases these movements are reversible. There is a risk that the movements may not be reversible. In addition there is a risk of developing hyperglycemia (high blood sugar), especially for individuals with at-risk conditions such as obesity, hyperlipidemia, diabetes, or a family history of diabetes.
3. I consent to treatment with an antipsychotic drug and recognize that my mental disorder represents a greater threat to my health than the involuntary movements, hyperglycemia or hyperlipidemia that I may develop. I understand that periodic examination will be conducted to screen for these adverse effects.
4. I understand that I can at any time, request that antipsychotic drug therapy be discontinued or resumed.

Individual or Guardian Print & Sign Name: _____ Date: _____

CLOZARIL ANTIPSYCHOTIC DRUG THERAPY CONSENT

1. To treat my mental disorder, the doctor recommends that I take, and continue to take, Clozaril, an antipsychotic drug. I have been informed that in the doctor's opinion, this is the most effective available therapy in improving/preventing a relapse of my mental disorder.
2. I understand that, if I continue drug therapy, I could develop involuntary movements of my mouth, tongue, and/or other body parts. I understand that in almost all cases these movements are reversible. There is a risk that the movements may not be reversible. In addition there is a risk of developing hyperglycemia (high blood sugar), especially for individuals with at-risk conditions such as obesity, hyperlipidemia, diabetes, or a family history of diabetes.
3. Clozaril may have serious adverse effects including bone marrow problems and seizures. The bone marrow problems may decrease white blood cell production which in turn could lead to infections. Your blood will be evaluated weekly at first than will be required bi-weekly and for maintenance screening will be collected monthly to check blood cell levels. Bone marrow problems can be very serious , although the vast majority of patients recover. Other adverse effects include sedation, dizziness, low blood pressure, constipation, and increased heart rate. Call your clinic or emergency medical services at once if fever or seizures occur.
3. I consent to treatment with Clozaril , a neuroleptic drug, and recognize that my mental disorder represents a greater threat to my health than the involuntary movements, hyperglycemia, hyperlipidemia or a decrease in white blood cells that I may develop. I understand that periodic examination will be conducted to screen for these adverse effects.
4. I understand that I can at any time, request that antipsychotic drug therapy be discontinued or resumed.
5. All my questions regarding my mental disorder, it's treatment and the risk of developing involuntary movements, hyperglycemia, hyperlipidemia or a decrease in white blood cells have been answered.

Individual or Guardian Print & Sign Name: _____ Date: _____

CONSENT for PSYCHOACTIVE MEDICATION TREATMENT DURING PREGNANCY

By signing below I acknowledge that I am in agreement with the following statements:
1. I have been informed of the dangers/risks of taking medication while pregnant.
2. My healthcare provider explained to me that taking medication may cause harm to my unborn baby.
3. My health care provider recommends that no medications be taken during pregnancy if possible.
4. I was advised to wait until the 2nd trimester to start taking medication if possible.
5. I was informed that I may change my mind at any time regarding the decision to take psychoactive medication during my pregnancy.
6. I will take full responsibility for the decision to take psychoactive medication during my pregnancy.

Individual or Guardian Print & Sign Name: _____ Date: _____

MD 39/41 03/08 RV: 9/08
File under Medical, on top of the Evaluation. EX: