

A Subsidiary of Psychiatric
Solutions, Inc

Informed Consent for Treatment with Psychoactive Medications

Antidepressants

Bupropion (Wellbutrin®)
Citalopram (Celexa®)
Duloxetine (Cymbalta®)
Escitalopram (Lexapro®)
Fluoxetine (Prozac®, Sarafem®)
Fluvoxamine (Luvox®)
Imipramine (Tofranil®)
Mirtazapine (Remeron®)
Paroxetine (Paxil®)
Sertraline (Zoloft®)
Trazodone (Desyrel®)
Venlafaxine (Effexor®)

Antipsychotics

Chlorpromazine (Thorazine®)
Haloperidol (Haldol®)

Second Generation

Antipsychotics

Aripiprazole (Abilify®)
Clozapine (Clozaril®)
Olanzapine (Zyprexa®)
Quetiapine (Seroquel®)
Risperidone (Risperdal®)
Ziprasidone (Geodon®)

Stimulants

Amphetamine salts (Adderall®)
Dexamethylphenidate (Focalin®)
Dextroamphetamine (Dexedrine®)
Methylphenidate (Concerta®,
Metadate®, Methylin®, Ritalin®)

Sedatives

Temazepam (Restoril®)
Zaleplon (Sonata®)
Zolpidem (Ambien®)

Anxiolytics

Alprazolam (Xanax®)
Chlordiazepoxide (Librium®)
Clonazepam (Klonopin®)
Clorazepate (Tranxene®)
Diazepam (Valium®)
Lorazepam (Ativan®)
Buspirone (Buspar®)
Hydroxyzine (Atarax®, Vistaril®)

Anticonvulsants

(Mood Stabilization)

Carbamazepine (Carbatrol®,
Eptol®, Tegretol®)
Divalproex (Depakote®)
Gabapentin (Neurontin®)
Lamotrigine (Lamictal®)
Oxcarbazepine (Trileptal®)
Topiramate (Topamax®)
Valproic Acid (Depakene®)

Miscellaneous

Atomoxetine (Strattera®)
Lithium (Eskalith®, Lithobid®)

The nature and purpose of treatment with the medication(s) listed in the left margin of this form have been fully explained to me and I am satisfied with the explanation provided. I understand all of the following:

1. The nature and seriousness of the mental condition for which the medication is recommended.
2. The reason for using the medication either by mouth or injection on a routine or as needed basis.
3. Psychoactive medications have the potential for side effects. These side effects may involve the heart, nervous system, muscles, glands, urinary tract, bowels, blood, eyes, skin, and allergic responses. (This list is not all-inclusive.) Most side effects are minor and reversible. However, some side effects are serious and may not be reversible, such as tardive dyskinesia, which is a movement disorder.
4. Monitoring serum concentrations of some medications (e.g., lithium, valproic acid, etc.) may be necessary. Also for patients receiving second-generation antipsychotics, baseline and follow-up monitoring of serum lipid and glucose concentrations, body weight, waist circumference, and blood pressure are recommended as alterations in these values may occur with treatment.
5. Some medications have dependence and/or abuse potential (e.g., stimulants, sedatives, anxiolytics) and may produce serious withdrawal symptoms upon abrupt discontinuation.
6. Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder and other psychiatric disorders. (See Medication Guide About Using Antidepressants in Children and Teenagers)
7. The improvement associated with psychoactive medications may be permanent or temporary. The medication will not cure the illness, but is recommended to help control the symptoms. Without medication the present mental condition may improve spontaneously, continue with little or no change, or worsen.
8. The medication recommended and/or dosage used may not be approved by the Food and Drug Administration for the assigned psychiatric diagnosis or for all age groups. However, data exists to support the use for which the medication is recommended.
9. Alternatives to treatment with medications are no treatment, psychotherapy, and/ or electroconvulsive therapy (the last is not available at this facility). These alternatives are not preferable to the recommended medication. I understand the prognosis with and without the recommended medication treatment.
10. I have the right to accept or refuse this medication treatment and the right to revoke consent at any time prior to or during treatment. This consent is being granted without threat or coercion expressed or implied. No guarantees or assurances have been made concerning the results of treatment with this medication.

I have read (or have had read to me) and do understand the foregoing. I have had the opportunity to have my questions answered. I understand the nature, purpose, and expected benefit of the recommended medication, the diagnosis and prognosis of the condition for which the medication is recommended, the alternatives to medication treatment including no treatment, and the significant risks and common side effects of the recommended medication. I do hereby give informed consent to treatment with the medication(s) checked in the left margin of this form.

Signature of Patient or Legally Authorized Decision Maker Relationship (if other than the patient) Date

Witness Date Time

Informed consent granted via telephone by _____
Name Relationship to patient

Witness Date Time

Witness Date Time