Ascension Behavioral Healthcare, P.A.

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

Name _____ Case # _____

My physician has prescribed the following type(s) of medication for the treatment of my mental problems:

[ ] Anticonvulsant Medications

[ ] Antidepressant Medications

[ ] Antipsychotic Medications (long-acting)

[ ] Antiparkinson Medications

[ ] Oral Antipsychotic Medications (Neuroleptics)

[ ] Stimulants

[ ] Antianxiety Medications

[ ] Anticyclic Medications
- [ ] Lithium
- [ ] Anticonvulsants

My physician has discussed with me the nature of my mental problems and the reasons why the above medication has been prescribed, including the likelihood of my mental problems improving with medication or not improving without medication.

If effective treatment alternatives to medication are available, my physician has discussed them with me.

It has been explained to me that effective medication may cause side effects in some people, but that most people experience few or no side effects. These side effects have been explained to me and I have been asked to notify staff as soon as possible if I develop any of these side effects.

I have been given a copy of a Medication Instruction Sheet explaining these side effects. All the risks, common side effects, and precautions that are listed on the Medication Instruction Sheet were discussed with m e and I had the opportunity to ask questions. _____

Consumer's/Representative's Initials

If neuroleptics have been prescribed, my physician has told me that this medication may produce persistent involuntary movements of the face and mouth and at times similar movements of the hands and feet. In certain cases these symptoms may be irreversible and may appear after the medication has been stopped. This side effect is usually associated with taking medication for more than three months and can be minimized by lowering the dosage of the medication and minimizing the use of other medications. It has been explained tome that periodic examinations will be conducted to see if such involuntary movements have developed.

I have been given an opportunity to ask any questions regarding my mental problems and the medication treatment.

Based on this explanation, I hereby consent to treatment with the above prescribed medication. I understand that I may withdraw this consent at any time.

_____ _____

Consumer's/Legally Authorized Representative's Signature Date

_____ _____

Physician's Signature Date

452 Lakeshore Pkwy * Suite 105 * Rock Hill, SC 29730 * Phone: (803)329-1915 * Facsimile: (803)329-1918