

<p>Harris County Psychiatric Center</p> <p>CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION</p>	
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Name of Medication: _____

The explanation was given to the individual in simple, non-technical language and included:	Indicate Accomplishment by a Checkmark
1) The nature of his/her mental and physical condition.	
2) The expected beneficial effects on his/her condition as a result of treatment with the medication(s).	
3) The probable health and mental health consequences of not taking medication, including the occurrence, increase or reoccurrence of symptoms of mental illness.	
4) The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefits as the medication(s) and why the physician rejects the alternative treatment.	
5) A description of the proposed course of treatment with the medication(s).	
6) The fact that side effects of varying degrees of severity are a risk of all medications.	
7) The relevant side effects of the medication(s) being prescribed are explained, including: A. any side effects which are known to frequently occur in most individuals; B. any side effects to which the individual may be predisposed; and C. the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time.	
8) The need to advise staff immediately if any of these side effects occur.	
9) An instruction that the individual may withdraw consent at any time without negative actions on the part of the staff.	
10) An offer to answer any questions concerning this treatment.	
11) A discussion on the black box warning(s) and addressed all questions satisfactorily	

I have received a complete explanation of the psychoactive medication(s) by means of: (Circle those appropriate)

Oral Explanation
 Video Presentation
 Printed Material
 Other

Based upon this explanation, I hereby consent to treatment with a specific psychoactive medication as indicated on this form. I understand that I may withdraw this consent at any time, however a probate court may decide that I lack the capacity to make the decisions whether or not to take the medication(s) and decide that I must continue taking the psychoactive medication prescribed by my physician.

Patient Signature	Date
Representative	Relationship to Patient
Date	Date
Physician, P.A., R.Ph., RN or LVN Giving Explanation	Position
Date	Date
Signature of Treating Physician - to confirm explanation given by P.A., R.Ph., RN or LVN (required within two working days of P.A., R.Ph., RN or LVN giving explanation)	Date

CONSENT FOR TREATMENT INVOLVING A MINOR:

If this consent is for treatment of a minor under Section 35.01, Texas Family Code, the following information must be provided:

- 1) Name of one or both parents, if known:
- 2) Name of legally authorized representative of person, if appointed:
- 3) Date on which treatment is to begin:

WITHDRAWAL OF CONSENT FOR MEDICATION:

I formally withdraw my consent for _____
 Name of Psychoactive Medication or Medication Group (Class)

Patient Signature	Date	Witness	Date
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