Comfort Minds & Above Behavioral Health
9500 Ray White Rd Ste 200
Fort Worth, Texas, US - 76244

Medication Consent: Psychotropics

PSYCHOTROPIC MEDICATION CONSENT I acknowledge that I have discussed with the prescribing physician the following for each listed psychiatric medication(s) as specified in this consent form, the reason(s) for taking such medication(s) and any alternative treatments. • The diagnosis and target symptoms for the medication recommended; • The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment; • The possible risks and side effects; including risk of medications to pregnant women and women who are breast feeding; • The possible alternatives and complementary treatments; • The possible results of not taking the recommended medications; • The possibility that my/ my child's medication dose and/or frequency may need to be adjusted over time, in consultation with my/my child's behavioral health medical practitioner; • Me/ my child's right to actively participate in treatment by discussing medication concerns or questions with my/my child's behavioral health medical practitioner; • Me/my child's right to withdraw voluntary consent for medication at any time (unless the use of medications in treatment is required in a Court Order or in a Special Treatment Plan); and • For persons under 18 years of age, the FDA status of medication and the level of evidence supporting the recommended medication. I acknowledge that the above topics were covered to my satisfaction, and that I have

consented to, and accepted the risks of treatment with the medication indicated in this form. I certify with my signature that I have the legal authority to sign this consent and that the relationship listed is valid and legal. Medication: Target Symptom: Type: Dosage Range: Frequency: Method: Oral Expected duration:1 year *

PATIENT/PARENT SIGNATURE *

NAME: *

RELATIONSHIP TO THE PATIENT: *

DATE: *