PSYCHOTROPIC MEDICATIONS PRESCRIPTION CONSENT

____ The nature of my mental conditions and the reasons for prescribing the specific medication(s) have been explained to me in terms that I understand

____ Alternative treatments and their benefits and disadvantages have been explained to me

____ The type of medication, the dosage, the range of frequency, the route of administration (oral/IM), and the anticipated length of treatment have been explained to me

____ I understand and accept the possible side effects of the following specific types of psychotropic medications which may include but are not limited to: Dizziness, drowsiness, muscle rigidity, tremors, dry mouth, blurry vision, diarrhea, appetite changes, changes in libido, changes in urination flow, ringing in the ears, changes in menstrual cycles, nausea, physical dependence, discontinuation syndrome, lowering of blood count, palpitations, feeling dizzy with quick movements (such as sudden standing), headaches, rash, insomnia or feeling sleeping are possible side effects.

____ I understand and accept additional possible side effects that may occur when psychotropic medications are taken for extended periods (over 3 months) include persistent involuntary movements of the face, mouth, or extremities (hand/feet). These symptoms are potentially irreversible and may appear after the medications have been discontinued

____ I understand that the use of psychotropic medication therapy may require certain lab tests on a regular required basis

____ I have informed the doctor of all my known allergies

____ I have informed the doctor of all medications I am currently taking, including prescriptions, over the counter remedies, herbal therapies, supplements, aspirin, and any other recreational drug or alcohol use.

____ I have been advised whether I should avoid drinking alcoholic beverages and consuming any or all of these medications while taking the psychotropic medication(s).

____ I am aware and accept that no guarantees about the results of the treatment have been made.

____ I have been advised of the probable consequences of declining recommended or alternative therapies.

____ The doctor has answered all of my questions regarding this treatment.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct Akinboyede Akinyemi, M.D., to provide treatment with the following psychotropic medication(s):

_____

Patient or Legal representative signature and date

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed treatment to the patient or the patient's legal representative, I have answered all questions fully, and I believe that the patient or legal representative (circle one) fully understands what I have explained.

_____

Physician Signature and date