Pinellas: 3840 5TH Ave N Saint Pete FL 33713 **Phone:** 727-367-2273 **Fax:** 727-800-6929 **Pasco:** 7340 Little Rd New Port Richie FL 34654

PSYCHOTRPIC MEDICATION CONSENT FORM

I _____ understand the risk benefit issues associated with treatment and psychotropic medications being prescribed and give my informed consent.

I am also familiar with HIPPA and confidentiality regulations that allow for sharing this information for insurance purposes.

I understand the importance of healthy living habits in the success of my treatment.

You are advised to abstain from alcohol and other substance of abuse.

History (Please circle all that Apply)

Major Depressive Disorder	Dysthymic Disorder	Bipolar Disorder
Mood Disorder NOS	PTSD	Generalized Anxiety Disorder
Panic Disorder	OCD	Social Anxiety Disorder
Tourette's	Autism	Asperger Disorder
Schizophrenia	Schizoaffective Disorder	Psychosis NOS
Substance Abuse Dependence	ADHD	ODD

Risk Awareness

I am aware of the potential side effects and risk of toxicity is suicide warning, serotonin syndrome, seizures, TD, EPS, neuroleptic malignant syndrome, weight gain, diabetes, metabolic syndrome, excessive sedation, decrease or increase blood pressure, addiction, withdrawal, seizures, priapism, sexual dysfunction, interactions with medications, Steven Johnson, toxicity to the heart, liver, pancreas, bone marrow, thyroid, risk for the baby in pregnancy, FDP rules and restrictions etc.

I have read and understand all the above risk associated with medication being prescribed:

_____

Patient Signature **Date**

_____

Guardian Signature **Date**