Consent To Take Medication

Larry K. Grubb, M.D. has advised me that medication is an appropriate treatment at this time. Dr. Grubb has discussed the nature of the patient's mental condition, the reasons for prescribing such medication(s), including the likelihood of improving or not improving with or without the medication(s). I have been informed of the type of medication(s) to be prescribed, how often and in what amount, for how long and by what route. I have been informed of common side effects that may occur when taking these medication(s) as well as have been given a hand out which describe common side affects associated with the medication(s) that are being prescribed.

I have been informed of the FDA issued black box warning about the increased risk of suicidal thoughts associated with the use of antidepressants as well as the possibility that antidepressants may cause increased irritability, restlessness and/or manic symptoms.

I have been informed of possible side effects that may occur when taking antipsychotic medication for extended periods of time. These include persistent involuntary movements of the face or mouth and at times, similar movements of the hands and feet. These symptoms of are potentially irreversible and may appear after the medication has been discontinued. I have also been informed that antipsychotic medications are associated with a risk of diabetes, hypertriglyceridemia and/or weight gain.

I have been informed that I have a right to revoke this consent for any reason, at any time. I have been advised and informed of all of the above by Dr. Grubb and provided with any other information I desire regarding the medication(s). I consent to the medication(s) as Dr. Grubb prescribes them.

Name of Medication: Initial Dose-Class of Medication

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Signature of Patient_____ Date _____

Printed Name of Patient_____

Signature of Parent/Legal Guardian _____
Date _____

Printed Name of Parent/Legal Guardian

_____

Larry K. Grubb, M.D.

Signature of Physician _____Date _____