The Therapeutic Center for Children and Families

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CONSENT FOR PSYCHOTROPIC MEDICATION

Upon completion of my and/or my child's psychiatric evaluation, I have been informed by The Diagnostic & Therapeutic Center that medication management is recommended.

The specific medication(s) to be prescribed is (are): _____

I (and/or my child) have been informed of the purpose of the medication(s) and have discussed any questions or concerns I (we) have about the medication(s). In addition, I (we) have been informed of any precautions that should be taken with administering the medication(s) as well as any potential side effects. I (we) believe that treatment with the noted medication(s) is justified in view of my (and/or my child's) diagnosis. The medication(s) has also been discussed with my child, appropriate to his/her level of understanding.

By signing below, I give my consent for the use of the medication(s) documented above.

Patient Name: _____

Client's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if applicable)

Parent/Guardian Signature: _____ Date: _____
(if applicable)

MD / APRN: _____

MD / APRN Signature: _____ Date: _____

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