Susan J Bloom Psy D, APNP, LLC

Informed Consent for Psychotropic Medication and Treatment Planning

I give consent for the administration of the following medication(s):

_____

_____

I have read and have been given the education materials about this/these medication(s). I have discussed the risks, benefits and other choices with my prescriber. I have been encouraged to ask questions, those that have been noted have been answered to my satisfaction and I agree to the treatment with the mediation(s).

I give my consent to the route of administration, dosage changes, or discontinuation with my knowledge. This consent will be valid for 15 months or unless I revoke the consent.

Frequency of Medication Management: ___biweekly___Monthly___every ___months

___Medication Management to decrease symptoms of _____

___Psychotherapy with _____Meds Only_____

___Patient has been assessed for suicidal/homicidal risk.

___No Risk

___High risk: Plan of Action: _____

___Moderate risk: Plan of Action: _____

___Low Risk: Plan of Action: _____

___Medications support the patients diagnosis of_____

Patient signature _____ Date_____

Legal Guardian/Parent Signature_____ Date_____

Witness_____ Date_____

I have discussed the administration of the medication listed above with the client. I have explained the potential risks, benefits and alternatives available. I have encouraged and answered questions. I have discussed the risks associated with using this medication in pregnancy with women of childbearing age who are pregnant or planning to become pregnant.

Prescriber _____Date_____