

INFORMED CONSENT FOR MEDICATION

Patient Name: _____ **Birthdate:** _____

Guardian Name: _____ **Relationship:** _____

Name of Pharmacy: _____

Pharmacy Address: _____

Pharmacy Number: _____

Renewed Journey Counseling Services, LLC offers psychiatric and psychotherapy treatments. When meeting with the psychiatrist the appointment will include the assessment of your mental health condition and treatment options.

During the visit, you and your physician will discuss:

1. The nature of your mental condition.
2. Your physician's reasons for prescribing the medication, including the likelihood of your condition improving or not improving without the medicine.
3. The importance of medication compliance and the option to discuss with your prescribing physician any desire to stop taking any medication.
4. Reasonable alternative treatments that are available for your condition.
5. There may be a need for initial or periodic medical or laboratory consultations with the use of these medication(s).
6. That certain antipsychotic medications may cause additional side effects for some persons, including tardive dyskinesia. Tardive dyskinesia is defined as persistent involuntary movements of the face, mouth, torso, hands, or feet. These symptoms are potentially irreversible, and may continue after the antipsychotic medication has been stopped.

I was given information about the recommended medication. I understand that the information does not cover everything, but it includes items of clinical significance to me. I should discuss all my medical problems and any medication that I take with my physician(s). For more information, I may refer to a pharmacist or to a standard text such as the Physician's Desk Reference (PDR).

| MEDICATION | CONT/NEW/D/C | DOSAGE | LIST OF COMMON SIDE EFFECTS |
|------------|--------------|--------|-----------------------------|
| | | | |
| | | | |
| | | | |
| | | | |



RENEWED JOURNEY COUNSELING SERVICES, LLC
1479 BROCKETT ROAD SUITE 101 TUCKER, GA 30084
O: (404) 625-5427 F: (404) 508-8944
WWW.RENEWEDJOURNEY.ORG

PSYCHIATRY FOLLOW UP VISITS:

Prescribing physicians provide prescriptions for medications during appointments. They will rarely approve refill requests from patients or pharmacies outside of an appointment.

This practice:

- reduces prescription errors,
- improves patient safety and
- encourages appropriate follow-up. It also,
- improves compliance with state laws governing controlled substances.

Patients receive enough medication or refills to last until their next **recommended** follow-up. It is therefore important to make and comply with follow-up appointments. Please be proactive in your care and track how much medication you have and how many refills remain on your prescription, and ensure you have an appointment to see the doctor before you run out of medication. In instances of emergencies, a fee applies when a patient needs a between-visits refill.

- I understand that I may refuse medication(s) unless the refusal would be unsafe to me/my child or others.
- Many psychiatric medications can cause sensitivity to sunlight or decrease the body's ability to handle heat when being used. Using sunscreen when outdoors and drinking fluids when sweating or in hot settings is good practice on or off medications.
- If there are questions about other potential side effects, I know I can contact the prescribing physician.
- I understand the potential benefits, side effects, and alternatives and I agree to the medication treatment recommended.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your provider, and you are authorizing your clinician to begin treatment with you. By signing this you also agree to undergo mental health treatment and understand that you can end treatment at any time. It should be discussed with your physician, but you always reserve the right to stop treatment.

Patient Name (Please Print)

Date

Patient Signature

If Applicable:

Legal Guardian's Name (Please Print)

Date

Legal Guardian's Signature