PSYCHOTROPIC MEDICATION CONSENT

I understand that I or (patient name) ______________________ have/has a diagnosis of

____

I agree to the use of (name of medication) _____________________________________
for my self/child as a part of treatment with Dr. Ayanna Cooke-Chen. I agree to keep regularly scheduled appointments for medication evaluations and psychotherapy, give/take medications as prescribed, and to cooperate with recommendations for diagnostic tests/consultations/physical examinations.

Dr. Cooke-Chen explained the following before I agreed to the use of the medication(s):

Please check off after explaining the following:

- o My/ my child's diagnosis
- o My/ my child's symptoms for which the medication is indicated: (specify) ____
- o The benefits and risks, including the following significant known side effects of the medication (specify) ____
- o The availability of clinical experience with this medication and probability of success
- o Alternatives to the use of this medication, if any (specify) __________________

I understand that although Dr. Cooke-Chen has explained the most common side effects of this treatment, there may be others. Also, I understand that the results of this treatment are not guaranteed. I will call Dr. Cooke-Chen if I have any concerns or questions about or observe any side effects to this medication. In addition, I have been given instructions verbally and written information regarding the following medication has been reviewed with me.

____

Signature: Date:

____

Signature of Child (if applicable): Date:

____

Signature of Parent or Legal Guardian (if applicable): Date: