



Informed Consent for Psychotropic Medication Administration

I, _____ hereby consent on the behalf of
(Client or Authorized Representative)

_____ to the administration of
(Individual's Name)

_____ (Medication Name w/dosage, route and
frequency)

Psychotropic Medication prescribed by doctor:

_____.

The purpose of the medication is to manage or treat the symptoms
for _____.

(Diagnosis)

Disclosure of and Understanding for Psychotropic Medication Treatment:

I have been informed of the benefits and or adverse consequences of this medication or treatment.

Benefits: _____

Adverse Consequences: _____

I have been informed of the side effects of this medication

The side effects are: _____

or **See attached sheet**

I or my Authorized Representative can revoke this consent at any time.

However, if I revoke this medication and or treatment consent, I agree to work with my team for an alternative treatment plan that better meets my needs.

The Individual has been informed of alternative medications, treatments, their side effects, risks and benefits.

I have been instructed on how I or my Authorized Representative can at any time raise concerns; ask questions about my treatment and the consent I have given.

I refuse the treatment of _____ Psychotropic Medication.

Team Member(s)	Printed Name	Signature	Date:
Individual			
Authorized Representative			