San Mateo County
Behavioral Health and Recovery Services

"CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328"

VERIFICATION OF CONSENT TO MEDICATION

Client Name _____ **MH Number** _____

This is to acknowledge that I have had a discussion with my/my child's physician, _____ M.D., concerning his/her prescription of the following checked medication(s,) some of which may not have U.S. FDA approval for the use(s) discussed. **We discussed side effects, some of which are listed below, for different medications. Not all known or potential side effects are listed. Please be also aware that you should not drive or use heavy machinery until you know how the medications below affect you.**

☐ **Antipsychotic** _____

Some possible side effects: nausea, vomiting, dizziness, weight gain, increased blood sugar/lipids, diabetes, sedation, restlessness, tremor, stiff muscles, tardive dyskinesia (involuntary movements of the head, neck, arms,) seizures, sexual problems, neuroleptic malignant syndrome (rare medical emergency marked by high fever, rigidity, delerium, circulatory and respiratory collapse.) Increased risk of stroke and death in elderly patients with dementia. Additionally for Clozapine: seizures; lowered white blood cell count leading to infections; and, rarely, damage to the heart.

☐ **Antidepressant** _____

Some possible side effects: nausea, vomiting, appetite/weight changes, headaches, dizziness, sedation, sleep disturbances, dry mouth, sexual/erectile problems, seizures, abnormal internal bleeding.
Especially in youth: suicidal thoughts and behavior, mood changes, sleep disturbances, irritability, outbursts, hostility, violence.

☐ **Anti-Extrapyramidal (EPS) Medications** _____

Some possible side effects: dry mouth, blurred vision, tiredness, dizziness, mental dulling, constipation, trouble urinating.

☐ **Antianxiety/Hypnotic** _____

Some possible side effects: drowsiness, trouble concentrating, confusion, clumsiness, dizziness, weakness, decreased reflexes, difficulty driving, loss of inhibition. I understand that I/my child should avoid alcohol.

☐ **Mood Stabilizer** _____

Some possible side effects: nausea, vomiting, skin rash, weight gain, dizziness, confusion, tiredness, **birth defects**. Additionally for Depakote: liver/pancreas problems, ovarian problems; for Carbamazepine: lowered blood count leading to infections; for Trileptal: possible serious rash, potentially life-threatening. Mood stabilizers have also been associated with increases in suicidal thoughts and behaviors.

☐ **Lithium** _____

Some possible side effects: nausea, vomiting, diarrhea, tiredness, mental dulling, confusion, weight gain, thirst, increased urination, tremors, acne, thyroid disorder, birth defects.

☐ **ADHD Medications** _____

Some possible side effects: loss of appetite, decreased growth, trouble sleeping, restlessness, nausea, change in blood pressure/heartbeat.
Additionally for Strattera: rare liver injury with possible jaundice (yellow skin and eyes,) abdominal pain, itchy skin, flu, dark urine. Additionally for Adderall/Amphetamine salts: risk of sudden unexplained death, primarily with (undetected) underlying cardiac structural abnormalities. Additionally for Concerta/methylphenidate: psychotic behavior including visual hallucinations, suicidal ideation, aggression or violent behavior.

☐ **Others** _____

Please read reverse side acknowledgement and agreement and initial.

I understand that I have the right to refuse this/these medication(s) and that it/they cannot be administered to me/my child until I have spoken with my/my child's physician and have given my consent to treatment with this/these medications. I may seek further information at any time that I wish, and I may withdraw my consent to treatment with the above medication(s) at any time by stating my intention to my/my child's physician.

I have read and initialed the reverse side.
I certify with my signature that I have legal authority to sign this consent and that the relationship listed is valid and legal.

_____	_____	_____
Client/Parent or Guardian/Conservator Signatures	**Legal Relationship**	**Date**
_____	_____	_____
Youth Signature (Optional)	**Physician Signature**	**Date**

☐ ***Client concurs, but chooses NOT to sign***

Acknowledgement and Agreement

In our discussion, my/my child's physician and I also spoke about the following subjects:

1. The nature of my/my child's mental condition.

2. The reasons that my physician has for prescribing the above medication(s), including the likelihood of improving or of not improving without such medication(s), the risks of treatment, and risks of no treatment.

3. Any reasonable alternative treatment available for my/my child's condition.

4. The type of medications that I/my child will be receiving, the frequency and amounts of dosages, the method by which I/my child will take the medication(s) (*injection or by mouth*), and the possible duration of such treatment. Medication information brochures are available upon request.

5. Possible drug interactions that may occur with other medications and drugs. I agree to notify my/my child's physician(s) regarding any medications, or changes in medications, prescribed by other physicians, and regarding use, or changes in use, of over-the-counter drugs or natural/herbal supplements.

I am aware that by signing this form I am acknowledging that I have held a discussion with my/my child's physician in which the above topics were covered to my satisfaction, and that I accept the risks of, and have consented to, treatment with the above medication(s). I understand/my child understands and agree(s) to the following:

1. I agree/my child agrees to take/administer the medication(s) as prescribed, and, especially when starting meds, in the first several months, and/or during changing doses, to watch for and contact my/my child's physician about any adverse effects. Emergency/911 will be contacted if adverse effects are serious.

2. Because they alter the mind, alcohol and/or recreational/street/illicit drugs should be avoided. They can also cause dangerous interactions and can adversely affect the intended actions of prescribed medications. Medications and/or drugs can impair the ability to drive or operate equipment, and I take responsibility for maintaining the safety of myself/my child, and the safety of others.

3. Discontinuing medications, especially abruptly, can cause serious adverse effects. I agree to discuss stopping medications with my/my child's doctor before doing so, and to follow medical advice about safely tapering medications if intending to discontinue medications.

4. Medications can damage an unborn baby. I am not/my child is not currently pregnant. I agree to inform my doctor if there is any possibility or intention of my becoming pregnant. I will inform my child's doctor if thee is a possibility that my child is now pregnant or possibly may become pregnant while on psychiatric medications.

I have read and acknowledged the above, and agree to the above conditions.

Client/parent or guardian/conservator initials _____