MH556
09/06/01

OUTPATIENT MEDICATION REVIEW

103.1 ATTACHMENT I

(Please read this form to the patient/legal guardian/conservator if necessary)

ave talked with my psychiatrist, Doctor _____ who has recommended that I/my child receive(s) medication(s) to treat symptoms of: _____

_____

The type(s) of medication(s) prescribed is checked below:

☐ **Antidepressant,** ☐ **Anxiolytic,** ☐ **Mood Stabilizer,** ☐ **Antipsychotic,** ☐ **Other** _____

Medication(s)	
1.	4.
2.	5.
3.	6.

I understand the dosage(s) and when to take the medication(s), and that any changes in medication dosage and/frequency during the course of treatment will be discussed with me.

I have been informed that some side effects are possible, including:

☐ Muscle stiffness/tremor, ☐ Drowsiness, ☐ Dry mouth/blurred vision/constipation,

☐ Nausea/appetite changes, ☐ Sexual problems, ☐ Pregnancy issues, ☐ Dizziness,

☐ Interactions with other drugs and food, ☐ Other: _____

_____

I understand that these are common side effects, and that there may be other less common ones. I also understand that I should promptly inform my psychiatrist or other staff member about any changes in my condition (e.g. dizziness, severe sedation, rash), if I become pregnant, and/or any new medications I may be prescribed for other conditions.

With some anti-psychotics I understand that the side effect, tar dive dyskinesia, is possible that may cause involuntary movement of the tongue, face, neck, limbs, or torso and which may persist even after stopping the medication.

I understand that I am not forced to take medication, but it is recommended that I first discuss my decision to stop medication with my psychiatrist.

I understand that my psychiatrist believes this medication will help me, but there is no guarantee as to the results.

I HAVE READ THIS FORM (OR IT HAS BEEN READ TO ME), IT HAS BEEN EXPLAINED TO ME, AND I AGREE TO TAKE THE MEDICATION(S) AS PRESCRIBED.

Signature: _____ (Patient) **Signature:** _____ (Parent/Legal Guardian/Conservator)

I HAVE EXPLAIN THE BENEFITS, SIDE EFFECTS AND RISKS OF THE MEDICATION(S) LISTED ABOVE AND HAVE OBTAINED THE PATIENT'S/GUARDIAN'S INFORMED CONSENT.

Signature: _____ (Psychiatrist) **Date:** _____

his confidential information is provided to you in accord with applicable Welfare and Institutions Code. Duplication of this information for further disclosure is prohibited without the prior written consent of the patient/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **MIS #:**

Agency: **Prov.#:**

Los Angeles County - Department of Mental Health