WHITMAN-WALKER HEALTH

Informed Consent to Treatment of Minor Involving Psychiatric Medication(s)

Diagnoses:

AXIS I	
AXIS II	
AXIS III	

I, _____ (Printed Name of Patient/Parent/Legal Guardian) (circle one) have been given information by my medical practitioner or the medical practitioner for my child or ward about the medications listed below.

For each medication listed below, I have been given the opportunity to discuss with the prescriber the following:

- The diagnosis and target symptoms for the medication recommended.
- The possible benefits/intended outcome of treatment.
- The possible risks and side effects.
- The possible alternatives.
- The possible results of not taking the recommended medication.
- The dosage and the possibility that my medication dose may need to be adjusted over time, in consultation with my medical practitioner.
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment are required in a Court Order)
- The medication may be used "off-label" for a particular condition (in the absence of FDA approval) and that the medical practitioner will indicate when a medication is being used in this manner.

Medication Name	Route	Dosage

I UNDERSTAND THAT THE MEDICATION INFORMATION PROVIDED TO ME AND MY SIGNATURE BELOW ACKNOWLEDGES THAT I CONSENT TO THE USE OF THIS/THESE MEDICATION(S).

OR

_____ COURT ORDER PROVIDED (copy attached)
Initials of medical provider to verify that a copy is attached

[Signatures on Next Page]

Printed Name of Patient:	**Date of Birth:**
Signature: *(If applicable)*	**Date:**
Printed Name of Parent/Legal Guardian:	
Relationship to Patient:	
Signature:	**Date:**
Printed Name of Prescribing Psychiatrist and Credential:	
Signature:	**Date:**