Intown Atlanta Psychiatry
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INFORMED CONSENT FOR PSYCHIATRIC MEDICATION

Purpose of this form: This form documents that you and your provider have discussed your medication to your satisfaction.

Your psychiatric provider has prescribed the following medication(s). Your provider has either told you about the medication, given you written information about the medication, or both. You are entitled to know the following information before deciding to take the medication:

1. What your condition or diagnosis is
2. What symptoms the medication will reduce and how likely the medication will work
3. What your choices are of getting better without the medication
4. What other reasonable treatments are available
5. The name, dosage, frequency, route of administration, and duration of medication
6. Any special instructions associated with the medication
7. The probable side effects of the medication known to commonly occur, and any particular side effects that are likely to occur in your particular case
8. The ability to drive, operate machinery, or other skilled tasks may be impaired by the medications. Alcohol or illicit drugs may worsen this effect
9. If you are pregnant, plan to become pregnant, or breastfeeding, your provider should be notified. Medications may pose known or unknown risks to the fetus or infant
10. Any special instructions about taking the medication(s)

Medication	Dosage	Route	Frequency	Max Daily Dose

- **By signing this form, you indicate that the medication has been explained to you to your satisfaction**
- **Even after signing, you can still refuse any dose or withdraw your agreement at any time**
- **You can request a copy of this consent form**

Please check one of the following:

☐ I have had the opportunity to receive verbal information with the provider and I consent to this treatment. I understand that I can ask questions about my medication at any time. (Informed Consent)

☐ I have had the opportunity to discuss information about the medication with my provider and I refuse to consent to the medication (Informed Refusal)

Patient Signature and Date	
Guardian Signature (if minor) and Date	
Psychiatric Provider Signature and Date	