NORTH POINTE PSYCHIATRY, PA
CONSENT FOR TREATMENT WITH PSYCHOACTIVE MEDICATIONS

Date: ________________________

Patien_______________________________________

It is my sole responsibility to ask questions and request more information if I needed in regards to nature of the disease and all medications those will be prescribing to me during my treatment at North Pointe Psychiatry, PA. If I am not satisfied I can refused to accept any treatment including medications without negative actions on the part of staff. I am also aware that before leaving after each office visit I can ask questions regards to following:

The nature of mental and physical condition.

The expected beneficial effects on condition as a result of treatment with the medication (s).

The probable health and mental health consequences of not taking medications, including the occurrence, increase or reoccurrence of symptoms of mental illness.

The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefits as the medication(s) and why the physician rejects the alternative treatment.

A description of the proposed course of treatment with medication(s).

The fact that side effects of varying degrees of severity are a risk of all medications.

The relevant side effects of the medication(s) being prescribed including:

- Any side effects which are known to frequently occur in most individuals;
- Any side effects to which the individual may be predisposed; and
- The nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time.
- Metabolic side effects such as weight gain and hyperglycemia including developement of Diabetes.

The need to advise staff immediately if any of these side effects occur.

A review of Patient’s Rights under the Consent to Treatment with Psychoactive Medication Rule (see MHRS 9-7.0).

WOMEN OF CHILD BEARING YEARS ONLY-

Risks of using these medications in pregnancy including drug interaction which would interfere with the effectiveness of my birth control

pill in current/future use, and the necessity to use alternate birth control measures.

If pregnant or breast feeding, I agree to discuss with my obstetrician or pediatrician before starting the medication(s).

It is my sole responsibility to receive complete explanation of psychoactive medication(s) before starting by means of:

Oral explanation or Printed Materiel. **AND** I understand that I may withdraw this consent at any time, refused to take certain medications and/ or can request for alternative treatment.

____ _________________________

Patient/Guardian Name (printed)

Date

____ _________________________

Patient/Guardian Signature

Date

____ ________________________

Office Staff Signature

Date