

GEORGIA DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

Informed Consent for Mental Health Medication

Facility: _____

Name: _____

GDC#: _____

DOB: _____

Race: _____ Sex: _____

Medication Informed Consent

MEDICATION:	ANTICIPATED DOSAGE RANGE:
TARGET SYMPTOMS AND BENEFITS:	
ALTERNATIVE MEDICATIONS ARE:	
SIDE EFFECTS/RISKS OF THIS TREATMENT:	
RISKS OF REFUSING THIS TREATMENT include but are not limited to: Continuation or worsening of your symptoms and distress and becoming less able to care for yourself. Other:	
LENGTH OF CARE: The medication usually begins to act within _____. Reliable benefits require regular, long-term usage. Your doctor may adjust the dosage during treatment, in most cases, to the minimum dosage that is needed. Your doctor may order laboratory tests from time to time to make sure that the medication is being given properly and is not causing medical problems.	
NOTIFICATION: You have the right to stop taking this medication at any time, but we strongly recommend that you talk to your doctor first. If you decide to stop taking the medication, it will not affect your ability to receive other MH services but may affect your ability to remain on your current MH level if you decompensate. Avoid excessive heat or dehydration while taking this medication. For female patients: Let your doctor know if there is a possibility that you are pregnant.	
I understand that by signing this form I am agreeing to be treated with this medication. Mental health staff have given me information about this treatment, including the reasons I am being treated and the information on this form. I have had a chance to ask any questions about my treatment I wished to ask. I understand that I can discuss any other questions I might have about my treatment with the doctor and that a copy of this form will be given to me.	
Date: _____	Patient Signature: _____
Date: _____	Prescribing Practitioner Signature: _____ Name/Title Stamp: _____
I have been advised to take this medication, but I am unwilling to take it as prescribed. The risks of not taking this medication have been explained to me.	
Date: _____	Patient Signature: _____
Date: _____	Prescribing Practitioner Signature: _____ Name/Title Stamp: _____