GEORGIA DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

Informed Consent for Mental Health Medication

Facility: _____

Name: _____

GDC#: _____

DOB: _____

Race: _____ Sex: _____

Tricyclic Antidepressant Informed Consent

MEDICATION: **ANTICIPATED DOSAGE RANGE:**

TARGET SYMPTOMS AND BENEFITS:

Alternative treatments may include other medications, activity and talk therapies.

SIDE EFFECTS/RISKS OF THIS TREATMENT: Drowsiness or sleepiness, dry mouth and eyes, constipation, mild tremor, sweating, mild agitation, weakness, or headache, ringing in the ears, nausea, poor heat tolerance, loss of weight or appetite. Suddenly stopping this medication may cause medical problems. In rare cases, this class of medications may cause life threatening irregularities in heart beats and, in depressed patients who are less than 24 years old, increased suicidality. Other conditions to watch for are:

RISKS OF REFUSING THIS TREATMENT include but are not limited to: Continuation or worsening of your symptoms and distress (including periods of depressed mood, irritability, loss of interest and enjoyment, and hopelessness), and becoming less able to care for yourself.

LENGTH OF CARE: The medication usually begins to act within 2-4 weeks. Reliable benefits require regular, long-term usage. Your doctor may adjust the dosage during treatment, in most cases, to the lowest 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:

Retention Schedule: Completed forms shall be placed in the offender's mental health file (section 5) and a copy will be given to the offender. At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.