Sacramento County Division of Mental Health
Child & Family Services Unit

Sacramento County Child & Family Mental Health

INFORMED CONSENT FOR TREATMENT WITH PSYCHOTROPIC MEDICATIONS

Client's Name: _____ ID NUMBER: _____

My doctor has talked with me about my psychiatric condition and has recommended the following medication(s):

Medication Name	Dosage Range	Target Symptoms

I understand that medication is only one part of my treatment, and that my therapist/case manager may provide services such as individual therapy, family counseling, behavioral program, special school services, skills training and case management. The doctor has provided me with information about the medication(s), has explained the risks/benefits of my taking or not taking the medication(s), risks/benefits of alternative treatments, and the risks/benefits of doing nothing. The doctor has given me a chance to ask questions and has answered them. I understand that I should inform any doctor of the medicines that I take. I also understand that it is advisable not to get pregnant, breast feed or use illicit drugs while taking medication(s) due to potential of birth defects and various possible drug interactions with some medications. By signing below, I accept the proposed treatment plan to start on the medication(s) discussed. I also understand that I can withdraw this consent at any time, in consultation with my doctor.

Signature of Client: _____ Date: _____
PLEASE PRINT NAME NEXT TO YOUR SIGNATURE)

Signature of Doctor: _____Date_____
(PLEASE PRINT NAME NEXT TO YOUR SIGNATURE)

Signature of Legal Guardian / Conservator :_____Date_____
(PLEASE PRINT NAME NEXT TO YOUR SIGNATURE)
(May be notified by phone for change of medications)

Copy given to client on _____(date). By attending physician: (signature) _____
(revised April 2005 LLS