FAMILY LIVING INSTITUTE

Psychiatric and Counseling Services

757.229.7927

Consent and Medication Treatment Acknowledgement

Individual Name: _____ _____Date:_____

The main treatment goal is to improve my ability to function. Taking the prescribed medication (s) to help me reach my goal, I do understand that I can help myself by following better habits such as exercise, weight control and the non-use of tobacco, illegal substances, and alcohol will give me a healthier lifestyle that will in turn give me the most successful outcome of my treatment.

Medication Prescribed:_____ Reason for use:_____ Start Date:_____ Discontinued Date:_____

☐ Dry Mouth ☐ Appetite Change ☐ Vision Change ☐ Confusion ☐ Tremors
☐ Sleep Changes ☐ Muscle Stiffness ☐ Stuffy / Runny Nose ☐ Weight Gain / Loss
☐ Insomnia / Drowsiness ☐ Rash / Itching ☐ Mood Swings
Other (specify):
_____

☐ M.D.
☐ PT.

Medication Prescribed:_____ Reason for use:_____ Start Date:_____ Discontinued Date:_____

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Other (specify): _____

☐ M.D.
☐ P.T.

I acknowledge that I have received verbal or written information from the psychiatrist and/or nurse regarding my medication which has been prescribed for me. The information includes therapeutic effects, side effects, and possible adverse events associated with use of the medication (s). I understand that if there are other side effects or unexpected changes in my condition, I should immediately notify my psychiatrist or nurse. I understand that I am not compelled to take this medication and that its therapeutic effects are not guaranteed.
My signature acknowledges that I consent to the medication treatment and have been informed of the side effects and medication treatment expectations.

_____ _____ _____ _____
Individual Signature Date Witness: Medical Staff Signature Date