City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

Name:
Client ID:
Program Code:

# Informed Consent for Psychiatric Medication(s) - Adult/Older Adult

THE PURPOSE OF THIS FORM IS TO DOCUMENT THAT YOU AND THE PROVIDER ORDERING YOUR MEDICATIONS (YOUR PRESCRIBER) HAVE DISCUSSED YOUR MEDICATION(S) TO YOUR SATISFACTION.

Your prescriber has ordered the following medication(s). You are entitled to know the following information before deciding whether to take the medication(s):

1. What condition or diagnoses you have that these medications are prescribed to address
2. Which symptoms the medication(s) should reduce and how likely the medication(s) will work
3. What are your chances are of getting better without taking the medication(s)
4. Reasonable options or alternatives to taking the medication(s)
5. Name, type (or class) of medication, dosage, dosage range, frequency of administration, route of administration and duration of each prescribed medication
6. Common side effects of the medication(s), including possible additional side effects which may occur beyond three months (long term), and may be potentially irreversible
7. If antipsychotic medications are prescribed, notice that antipsychotic medications may cause additional side effects for some persons, including persistent involuntary movements which are potentially irreversible, and may continue after the antipsychotic medication has been stopped
8. Any special instructions you should know about taking the medication(s)

| Medication | Route | | Dosage Range |
|---|---|---|---|
| | ☐ Oral | ☐ Inject | |
| | ☐ Oral | ☐ Inject | |
| | ☐ Oral | ☐ Inject | |
| | ☐ Oral | ☐ Inject | |
| | ☐ Oral | ☐ Inject | |

- By signing this form, you indicate the above medication(s) have been explained to your satisfaction in your preferred language, and understand that you can ask questions about your medication(s) at any time.
- By signing this form, you consent to this treatment.
- After signing, you can still refuse any dose or withdraw your agreement at any time by notifying your prescriber either verbally or in writing.
- You will receive a copy of this consent form.
- You have received information about the medications in your preferred language by means of:
  ☐ Oral explanation ☐ Printed material ☐ Other_____

| | Date |
|---|---|
| **Client Signature:** | |
| **Prescriber Name (print):** | |
| **Prescriber Signature with type of professional degree, and licensure or job title:** | |
| **Witness (required if client unable or signs with a mark):** | |

**If unable to obtain a signature, please check the box below and document the reason:**

☐ The client verbally consents to the recommended medication(s), but is unable or refuses to sign because:

Continued attempts to obtain signature: Initials_____Date_____Initials_____Date_____

# Procedure for Informed Consent for Psychiatric Medication(s) - Adult/Older Adult form (MM05)

**Purpose:**

1. To serve as a record of the client's consent to take psychiatric medication(s) as part of a treatment regimen
2. To document that the client has been provided information about the medication(s) being prescribed

**Responsibilities for Documentation:**

1. Refer to policy 3.5-04 "BHS Psychiatric Medication Consent in Ambulatory Care".
2. In situations when a non-electronic form is used such as for some field services, complete this form and document the consent in the electronic Avatar Medication Consent form.
3. The prescriber has the responsibility for filling out the form once the client has received information about the medication(s) in their preferred language.
4. A new consent form must be executed when any new medication(s) are started.
5. A copy of the completed consent form shall be given to the client.
6. The completed form must be filed permanently in the medical record.
7. The consent process shall be documented in the electronic health record.

**Instructions:**

1. The client shall receive information about the medication(s) in their preferred language before the form is completed.
2. The medication(s), route(s), and dosage range(s) are entered into the table for up to five medications.
3. If the client consents to medication(s), the client and prescriber sign and date the form.
4. If the client verbally consents to medication(s) but is unable or refuses to sign the form, check the applicable box. The prescriber shall sign and date the form and document the reason for not signing. The prescriber documents continued attempts to obtain a signature by initialing and dating the appropriate line.
5. If the client is unable to sign or signs with a mark, a third party witness must co-sign.
6. Prescriber signatures on the medication consent must include the person's type of professional degree, and licensure or job title.