TREATMENT PLAN & INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

You have the right to be informed about your care and to ask questions. You have the right to accept or reject any of your care plan. You have the right to end your consent verbally or in writing at any time. You have the right to end your consent verbally or in writing at any time. You have the right to acopy of this Treatment Plan & Consent. Copy requested? YES NO You have the right or copy of this Treatment Plan & Consent. Copy requested? YES NO Emergency Treatment: An emergency is a temporary, sudden marked change requiring action to preserve life or prevent serious bodily harm to client or others. In certain emergencies, medication may be given to you when it is not possible to get your consent. However, once the emergency has passed, your informed consent is required. Prescriber will discuss with you the information below: 1. Nature and seriousnes of your mental illness. Diagnosis: 2. Reason(s) for medication(s) including the likelihood of improving, or not improving with or without the medication(s), i.e. Symptoms 3. Reasonable alternative treatments and why provider is recommending this particular treatment. Document alternative, if applicable: 4. Commonly known probable side effects that you may experience: 5. Possible additional side effects which may happen when taking medication(s) longer than three months: If taking a typical or atypical anti-psychetic medication, you will be given information about a possible side effect called tardive dyskinesia. It is characterized by involuntary movements of the face, mouth and/or hands and feet. These symptoms are potentially ireversible and may appear after medication has been						
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Above information explained to client? \Box YES \Box NO

TREATMENT PLAN & INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION Page 1 of 2

Client:

DOB:

Optum Public Sector San Diego Funding for services is provided by the County of San Diego Health & Human Services Agency

TREATMENT PLAN & INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

Client Statement

Based on the information I have read, discussed and/or reviewed with my prescribing provider (check one)

I understand and give consent to this treatment plan for psychotropic medication(s) on page one.

I give verbal consent only; unwilling or unable to sign form.

□ I **<u>do not</u>** consent to take the psychotropic medication(s) listed below.

Please list:

Client/Legal Rep./Guardian Signature

Prescriber Statement

Date

Date

Date

I have reviewed, discussed and recommend the treatment plan (page 1) for above client and:

Client gives consent to this treatment plan for Psychotropic medications.

Client gives verbal consent, but unwilling or unable to sign.

Client given medication without consent due to emergency.

Client unable to understand risks and benefits, and therefore cannot consent.

Other Comments:

Prescriber Signature and License

Prescriber Printed Name and License

Witness Signature (if applicable):

Notice of Privacy Practices has been provided as required by HIPPA **YES NO**

State Guide to Medi-Cal Behavioral Health Services and the grievance/appeal process was provided **YES NO**

TREATMENT PLAN & INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION Page 2 of 2

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