Sacramento County Mental Health
INFORMED CONSENT FOR PSYCHOTROPIC DRUG TREATMENT OUTPATIENT SERVICES

TYPE*	MEDICATION NAME	MD NAME	CONSENTER'S SIGNATURE	DATE	INFO SHEET GIVEN
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***AD=** Antidepressant **AP=** Antipsychotic **AA=** Anti-anxiety **MS=** Mood Stabilizer **CE=** Cognitive Enhancer **O=** Other

My doctor explained the diagnosis and reasons for the above medications, including risks and benefits of treatment, the likelihood of improving without medications, and other possible alternative treatments.

The most common side effects of these drugs have been explained. I understand that if other side effects occur, I should promptly notify my doctor or nursing staff. I have been given drug information sheets for my medications, unless I did not want/or refused them.

I voluntarily give permission to use medication to treat my mental illness. I understand I may withdraw consent any time by telling this to medical staff. I understand stopping my medication without consultation with my physician may result in a relapse of my condition.

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Print Client's Name Date