Banner University Health Plans
Banner – University Family Care

Informed Consent for Psychotropic Medication Treatment

I have discussed the following information with my behavioral health medical practitioner for each medication listed below:

- The diagnosis and target symptoms for the medication recommended;
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects, including risks of medication to pregnant women and women who are breast feeding;
- The possible alternatives;
- The possible results of not taking the recommended medication;
- The possibility that my medication dose may need to be adjusted over time, in consultation with my behavioral health medical practitioner;
- My right to actively participate in my treatment by discussing medication concerns or questions with my behavioral health medical practitioner;
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment is required in a Court Order or in a Special Treatment Plan); and
- For persons under 18 years of age, the FDA status of the medication and the level of evidence supporting the recommended medication.

I understand the medication information that has been provided to me. By signing below, I agree to the use of each medication.

	How discussed**				
Medication	☐ In-person ☐ Telephone ☐ Tele-medicine ☐ Previously	Person/guardian initials ***		Behavioral Health professional initials	
		Date		Date	
Target Symptoms to be addressed*					
	How discussed**				
Medication	☐ In-person ☐ Telephone ☐ Tele-medicine ☐ Previously	Person/guardian initials ***		Behavioral Health professional initials	
		Date		Date	
Target Symptoms to be addressed*					
	How discussed**				
Medication	☐ In-person ☐ Telephone ☐ Tele-medicine ☐ Previously	Person/guardian initials ***		Behavioral Health professional initials	
		Date		Date	
Target Symptoms to be addressed*					
	How discussed**				
Medication	☐ In-person ☐ Telephone ☐ Tele-medicine ☐ Previously	Person/guardian initials ***		Behavioral Health professional initials	
		Date		Date	
Target Symptoms to be addressed*					

Parent/Guardian Printed name		Signature		Initials	
Clinician obtaining Consent – printed name		Signature		Initials	

*Target Symptoms refer to specific symptoms associated with a diagnosis, such a tearfulness, hallucinations, insomnia. List the target symptoms rather than the underlying diagnosis.

** “Previously” indicates the medication had been discussed in a previous setting (hospital, another clinic, etc.) or by another behavioral health medical practitioner and you are verifying that the person continues to consent to treatment with this medication.

***Ensure informed consent form with original patient signature is located in patient’s file. If consent obtained by telephone or through tele-medicine, individual may initial and date at next face-to-face visit.

Last Revision: 01/01/2018
Effective Date: 01/01/2018

Person’s Name ____________ Person’s ID# ____________