MH 556
Revised 9/26/16

OUTPATIENT MEDICATION REVIEW

I have talked with my psychiatrist or nurse practitioner, ______________, who has recommended that I / my child receive(s) medication(s) to treat symptoms of___________________________________. We have also talked about reasonable alternatives, such as: ____

☐ No reasonable alternatives available at this time.

The type(s) of medications prescribed is identified below:

Medication(s)	Type Antidepressant, Anxiolytic, Mood, Stabilizer, Antipsychotic, Other	Dosage (including PRN)	Frequency	Method (Oral/Injection)	Duration
1.					
2.					
3.					
4.					
5.					
6.					

- I understand the dosage(s) and when to take the medication(s), and that any changes in medication dosage and/or frequency during the course of treatment will be discussed with me.
- I have been informed that some side effects are possible, including:
  ☐ Muscle stiffness/tremor ☐ Drowsiness ☐ Dry mouth/blurred vision/constipation
  ☐ Nausea/appetite changes ☐ Sexual problems ☐ Pregnancy issues ☐ Dizziness
  ☐ Interactions with other drugs, food & health conditions ☐ Diabetes ☐ Weight Gain
  ☐ Other ____
- I understand that these are common side effects, and that there may be other less common ones. I also understand that I should promptly inform my psychiatrist or nurse practitioner about changes in my condition (e.g. dizziness, severe sedation, rash), if I become pregnant, and/or any new medications I may be prescribed/take for other conditions.
- **In addition to the above mentioned side effects, I understand there may be additional long term use side effects (present after 3 months)** such as: ☐ None other than those listed above
  ☐ Describe long term side effects not identified above ____
- With some anti-psychotics I understand that there is a possible side effect, tardive dyskinesia, which may cause involuntary movement of the tongue, face, neck, limbs, or torso and may persist even after stopping the medication.
- I understand that the decision to take medication is up to me, but that I should always first discuss with my psychiatrist/nurse practitioner any decision to stop taking medication.
- I understand that my psychiatrist/nurse practitioner believes this medication will help me, but there is no guarantee as to the results.

☐ **I HAVE READ THIS FORM** ☐ **THIS FORM HAS BEEN READ TO ME**

☐ **THIS FORM WAS INTERPRETED IN __________________FOR ME.**

If a translated version of this Form was signed by the client and/or responsible adult, the translated version must be attached to the English version.

THE INFORMATION ON THE FORM HAS BEEN EXPLAINED TO ME , AND I AGREE TO TAKE THE MEDICATION(S) AS PRESCRIBED. I UNDERSTAND THAT I MAY WITHDRAW CONSENT AT ANY TIME.

Signature: ___________________________________ **Signature:** ______________________________
(Client) (Parent/Legal Guardian/Conservator)

I HAVE EXPLAINED THE BENEFITS, SIDE EFFECTS AND RISKS OF THE MEDICATION(S) LISTED ABOVE AND HAVE OBTAINED THE PATIENT'S/RESPONSIBLE ADULT'S INFORMED CONSENT.

Signature: ___________________________________ **Date:** __________
(Psychiatrist or Nurse Practitioner and Discipline)

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Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health