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)

**This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.**

**Name:** **DMH ID#:**

**Agency:** **Provider #:**

**Los Angeles County – Department of Mental Health**