Neal Mazer, M.D. MPH
Informed Consent for Psychiatric Medications

Name of Patient:______________________________ Date___________

Birthdate:___________   Diagnosis:_________________________

Name of Parent if Minor__________________________

Your prescriber has ordered the following medication(s). Your prescriber has either told you about the medication(s) or given you written information or both. You are entitled to know the following information before deciding whether to take the medication(s).

1. Your condition or diagnosis. 2. What symptoms the medication(s) should reduce and how likely they are to work. 3. What your chances are of getting better without the medication(s). 4. What other reasonable treatments are available. 5 The name, dosage, frequency, route of administration and duration of prescribed medication(s). 6. Side effects of medication(s) known to commonly occur. 7. Any special instructions about taking medication(s).

Medication	Daily Dosage Range	Dose Changes, Date/Initials

By signing this form you indicate that the medication(s) have been explained to you to your satisfaction.
Even after signing you can still refuse any dose or withdraw your agreement completely at any time

_____I have had the opportunity to receive information about my medication(s) from the prescriber, and I consent to this treatment. I understand that I can ask questions about my medication at any time.

Patient Signature____

Guardian (if patient is a minor)__________________________________

Neal Mazer, M.D., MPH Signature________________________________