Antipsychotic Consent Form

I _____ understand that certain medications known as antipsychotics may be very helpful in treating my clinical condition. Risperdal, Zyprexa, Seroquel and Geodon are some of the newer antipsychotics. Haldol, Prolixin, Clozaril, and Thorazine are examples of older antipsychotics.

These medications can help me think more clearly, feel less aggressive and hostile, and can decrease other psychiatric symptoms. Some of them may help my mood. If I take these medicines regularly, they may keep many of my symptoms from coming back. My prescribing health care provider cannot guarantee how I will respond to any of these medications.

I have talked with my prescribing health care provider about common side effects seen with these medicines. We have talked about tardive dyskinesia (TD). I understand TD can cause irreversible movements of my mouth, jaw, tongue, hands, feet, or body. I know it often happens when you take an older medicine for a long time, and that it can occur spontaneously even when someone has never taken these medicines. The newer antipsychotics can cause it too, but much more rarely than the older medicines. Sometimes it shows up after medicine is stopped or decreased. I have been advised by my prescribing health care provider to report any symptoms of TD, or other problems related to taking my medicine, as soon as possible.

My prescribing health care provider and I have talked about different treatments for my symptoms and we believe that antipsychotic medicines may help my illness. We have discussed that these medications have not been approved for the treatment of behaviors associated with dementia and may increase the risk of death when used even as directed and carry a FDA black box warning. We discussed that these medications can increase the risk of falls. We have agreed to try these medications in an attempt to relieve suffering and improve my quality of life.

My prescribing health care provider will try to answer any questions I have about these medicines. We will work together if we need to change the dose of my medicine, switch from one medicine to another, or stop my treatment. I will take these medicines as prescribed by my prescribing health care provider for the treatment of my clinical condition.

Patient or Power of Attorney Signature Date

Witness Date

Prescribing Health Care Provider Date

* If the patient cannot fully understand this form, a family member, legal guardian, or agent named in a health care power of attorney may be asked to sign as a substitute decision maker. The consent process may be completed by telephone when necessary