Advanced Psychiatry of Elgin
Child, Adolescent and Adult Psychiatry
2130 Point Boulevard, Suite 200
Elgin, IL 60123
Telephone: 847.783.0307 Fax: 847.783.0730

MEDICATION CONSENT FORM

I give my consent on ______________________________ for physician
Date

to prescribe medications to _____________________________________.
Patient's Name

MEDICATIONS PRESCRIBED:

- ____
- ____
- ____
- ____

THE FOLLOWING WAS EXPLAINED/PROVIDED TO ME:

1. Benefits of Treatment and diagnosis information
2. Administration of Treatment
3. Alternative to treatment modes
4. Consequences of not receiving proposed treatment
5. I have been advised of the name, frequency, and potential side effects of the medications being prescribed to me.
6. I have been advised that if I am of **Child Bearing Age** to avoid becoming pregnant while taking psychotropic medication, and to notify my psychiatrist immediately upon becoming pregnant.
7. I understand that certain medications are not F.D.A. approved for the specific indication, especially in children. Such uses are called off label uses and are not illegal.

____ _________________________________
Patient's Signature Date

____ _________________________________
Parent/Guardian Signature Date

(Patients 12 to 18 must sign in addition to the parent)

Revised 5/06/15