McLaren
GREATER LANSING

Informed Consent for Psychiatric Medication(s)–Adult/Older Adult

The purpose of this form is to document that you and your physician ordering your medication(s) have discussed:

- **Name of medication, type (or class) of medication, dosage, dose range, frequency of administration.**
- **What condition or diagnosis you have that these medications are prescribed to address.**
- **What are your chances of getting better without taking the medication(s).**
- **Common side effects.**
- **Any special instructions you should know about taking the medication(s).**

Class (or Type) of Medication my physician has prescribed for me

By signing this form, you indicate the medication(s) have been explained to your satisfaction and understand that you can ask about your medication(s) at any time.

By signing this form, you have received information about the medication(s) by means of oral explanation or printed materials.

Patient / or Guardian Signature:	**Date/Time:**

I have explained to the above-named patient or guardian the name of the medication(s), and side effects. In my clinical judgement, he or she is mentally competent to understand the use of the medication(s).

Physician Signature:	**Date/Time:**

PT.

MR.#/P

DR.